STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

MEDICAL BOARD OF CALIFORNIA – Executive Office
1434 Howe Avenue, Suite 92, Sacramento, CA 95825
(916) 263-2389 Fax (916) 263-2387 www.mbc.ca.gov

DIVISION OF MEDICAL QUALITY QUARTERLY MEETING

July 27, 2007

Embassy Suites
250 Gateway Boulevard
South San Francisco, CA 94080
(650) 589-3400

Action may be taken on any items listed on the agenda

AGENDA

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

TIBURON/SAUSALITO ROOM

Friday, July 27, 2007

8:00 a.m. – 10:00 a.m. OPEN SESSION

1. CALL TO ORDER; ROLL CALL

2. Approval of Orders Restoring License Following Successful Completion of Probation, Orders Issuing Public Letter of Reprimand, and Orders for License Surrender During Probation

3. Approval of the April 27, 2007 Minutes

4. Legislation and Regulation Update (For Items A and B, refer to legislative packet and regulation matrix.)
   A. 2007 Legislation
   B. Status of Regulatory Action

5. Consideration of Proposal to Amend Oral Argument Regulations (Kirchmeyer/Zerunyan/Heppler)

6. Division Chief's Report (Threadgill)
   A. Medical Expert Program Survey
   B. Expert Utilization Report

7. Vertical Enforcement Update/Progress Report (Ramirez/Threadgill)

8. Discussion of Federal and California Appellate Decisions Pertaining to Medical Marijuana (Deputy Attorneys General Simon and Mercer)

9. Proposed Designation of Precedential Decisions pursuant to Government Code §11425.60 (Scuri)
   A. In the Matter of the Accusation Against Joseph J. Basile, M.D. (Case No. 03-2000-108170 and OAH No. N2002050521)
   B. In the Matter of the Accusation Against Tod H. Mikuriya, M.D. (Case No. 12-1999-98783 and OAH No. N2002110020)

10. Report Regarding Practice Monitoring Conditions (Lynda Swenson)

11. Report on Surgical or Procedural Deficiencies (William Norcross, M.D.)

12. Diversion Program Report (Valine)
   A. Program Status
   B. DEC Member Re-Appointments
   C. Consideration of Proposals to Amend/Add Regulations
      1. Regulatory Criteria for Admission to and Termination from the Diversion Program
      2. Criteria for the Ordering of a Clinical Competency Examination
      3. Response to Relapses

13. Items for November 2007 Division Meeting

14. Public Comment on Items Not on the Agenda

15. Adjournment

PANEL A: Dr. Aristeiguieta (Chair), Mr. Alexander, Dr. Chin, Dr. Duruisseau, Ph.D., Dr. Low & Dr. Moran

UNION SQUARE/GHIRADELLI ROOM

Friday, July 27, 2007

1:00 p.m. OPEN SESSION

CALL TO ORDER; ROLL CALL

Oral Argument on Nonadopted Proposed Decision

1. FISCHBEIN, Stuart James, M.D.

1:45 p.m. *CLOSED SESSION – Nonadopted Proposed Decision

FISCHBEIN, Stuart James, M.D.

2:00 p.m. OPEN SESSION

Oral Argument on Nonadopted Proposed Decision

2. HALIL, Saihb Sinuhe

**The Division and/or Panel of the Division will convene in Closed Session, as authorized by Government Code Section 11126(c)(3), to deliberate on disciplinary decisions and stipulations.*

****

For additional information, call A. Renee Threadgill, Chief of Enforcement, at (916) 263-2389.
Listed times are approximate and may be changed at the discretion of the President/Chair.

2:45 p.m. *CLOSED SESSION – Nonadopted Proposed Decision

HALIL, Saihb Sinuhe

3. Deliberation on disciplinary matters, including decisions and stipulations.

OPEN SESSION

Adjournment

PANEL B: Ms. Yaroslavsky (Chair), Dr. Corday, Ms. Dominguez, Dr. Moy, Dr. Salmonson, Dr. Wender & Mr. Zerunyan

TIBURON/SAUSALITO ROOM

Friday, July 27, 2007

1:00 p.m. OPEN SESSION

CALL TO ORDER; ROLL CALL

***CLOSED SESSION**

4. Deliberation on disciplinary matters, including decisions and stipulations.

OPEN SESSION

Adjournment

Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Open Meetings Act. The audience will be given appropriate opportunities to comment on any issue presented in open session before the Board, but the President may apportion available time among those who wish to speak.

****

For additional information call (916) 263-2389.

NOTICE: The meeting is accessible to the physically disabled. A person who needs disability-related accommodations or modifications in order to participate in the meeting shall make a request to the Board no later than five working days before the meeting by contacting Teresa Schaeffer at (916) 263-2389 or sending a written request to Ms. Schaeffer at the Medical Board of California, 1426 Howe Avenue, Suite 54, Sacramento, CA 95825. Requests for further information should be directed to the same address and telephone number.

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Agenda Item 3

DIVISION OF MEDICAL QUALITY

Sacramento Convention Center
Sacramento, CA

April 27, 2007

MINUTES

Agenda Item 1

A quorum was present and due notice having been mailed to all interested parties, the meeting was called to order at 8:01 a.m. Members present included:

Members Present:
Cesar A. Aristeiguieta, M.D., President
Barbara Yaroslavsky, Vice President
Steve Alexander
Shelton Duruisseau, Ph.D.
Reginald Low, M.D.
Mary L. Moran, M.D.
Ronald L. Moy, M.D.
Janet Salmonson, M.D.
Ronald H. Wender, M.D.
Frank V. Zerunyan

Members Absent:
Stephen R. Corday, M.D., Secretary
John Chin, M.D.
Dorene Dominguez

Staff and Guests Present:
David T. Thornton, Executive Director
Renee Threadgill, Chief of Enforcement
Kurt Heppler, DCA Legal Counsel
Carlos Ramirez, Senior Assistant Attorney General
Stephen Boreman, Deputy Attorney General
Candis Cohen, Public Information Officer

Linda Whitney, Chief of Legislation
Kevin Schunke, Regulation Coordinator
Kelly Nelson, Legislative Analyst
Paulette Romero, Associate Analyst
Janie Cordray, Research Program Manager
Frank Valine, Diversion Program Manager
Camille McGee, Associate Analyst
Richard Prouty, Staff Services Manager
Teresa Schaeffer, Associate Analyst
Valerie Moore, Associate Analyst
Arlene Krysinski, Associate Analyst
Brenda Allen, Staff Services Analyst
Richard Acosta, Staff Services Analyst
Laura Sweet, Area Supervisor - L.A. Metro
Julie D'Angelo Fellmeth, Center for Public Interest Law
Sandra Bressler, California Medical Association
Brett Michelin, California Medical Association
James Hay, M.D., California Medical Association
Zennie Coughlin, Kaiser Permanente Medical Group
Frank Lucido, M.D.
Sashia Kim, Consultant, Senate Office of Research

Agenda Item 2 Approval of Orders

Approval of Orders Restoring License Following Completion of Probation
The Division reviewed and approved 12 Orders. Vote: 9-0

Approval of Orders Issuing Public Letters of Reprimand
The Division reviewed and approved 4 Orders. Vote 9-0

Approval of Orders for License Surrender During Probation/Administrative Action
The Division reviewed and approved 3 Orders. Vote 9-0

Agenda Item 3 Approval of Minutes

It was M/S (Salmonson/Wender) to approve the Open Session minutes of the February 2, 2007 Division Meeting. Motion carried (9-0).

Agenda Item 4 Legislation and Pending Regulations

No report was given.

Agenda Item 5 Diversion Program Report

Frank Valine, Diversion Program Administrator, provided an overview of the Diversion Committee's meeting held on April 27, 2007.

It was M/S to approve the appointment of Steven Oppenheim, M.D. as a new DEC member. Motion carried unanimously.

It was M/S to approve the appointments of Lee Snook, M.D., Barry Rosen, M.D., David Pating, M.D., Stephanie Shaner, M.D., Marvin Firestone, M.D., J.D., Thomas Ciesla, M.D., Bruce Kaldor, M.D., and Shannon Chavez, M.D. as Diversion Advisory Council members. Motion carried unanimously.

The audit of the Diversion Program has been completed and no major problems were found. The auditor's report will be released in June 2007.

The Diversion Advisory Council has been assigned the task of developing guidelines for determining when a competency examination should be ordered. A report on their findings will be presented at a future board meeting.

Agenda Item 6 Division Chief's Report

Renee Threadgill, Chief of Enforcement, reported the probation program is currently undergoing reorganization, which will result in a reduction of the assigned workload for all investigative staff and aid in the reduction of the processing time for the cases in the vertical enforcement model. The Board's current Investigator Assistant positions will be converted to an existing classification within the Department of Consumer Affairs, possibly Inspector or Field Representative, and the sworn investigators who currently monitor probationers will be transferred to the district offices and assigned active investigations.

Due to funds seized through Asset Forfeiture, the Board will hold an investigator training conference on May 15-17, 2007. Dr. Aristeiguieta, Mr. Alexander and Dr. Fantozzi have offered their support and will be in attendance.

Agenda Item 6A Medical Expert Program – Survey

Ms. Threadgill stated the overall comments from the experts surveyed are favorable. Some suggestions for program improvement are being reviewed and ways in which to exchange more information with the experts are being developed.

After much discussion, the DMQ members directed staff to research the financial impact on the Board for increasing expert reviewers' pay; to solicit applications for expert reviewers; and to include recruitment information for medical experts in each Newsletter.

Sandra Bressler, California Medical Association, offered CMA's continued support in recruitment of new medical experts. She cautioned the Board about the potential of overusing

current medical experts.

Ms. Threadgill commented the Board continually monitors the use of the experts in order to ensure they are not being over utilized. A quarterly report on the use of the medical experts is prepared and will be made available for review.

Agenda Item 6B Vertical Enforcement Update/Progress Report

Carlos Ramirez, Senior Assistant Attorney General, stated the AG's office has modified its procedure in processing cases in the vertical enforcement model to be closer to what was envisioned during the discussion leading to SB231. Cases are now being assigned to the trial deputies within 72 hours of receipt in the district offices and other locations. Problems with co-location and shared database systems exist, however, solutions on how to make the process run smoother are being sought.

It was M/S (Alexander/Wender) for staff and management to move forward with finding solutions to bring the investigators and the AG's office staff closer together to a workable vertical enforcement model. Motion carried unanimously.

Agenda Item 7 Federal and California Appellate Decisions Pertaining to Medical Marijuana

It was M/S (Duruisseau/Zerunyan) to move the discussion of this agenda item to the DMQ's July 2007 meeting. Motion carried unanimously.

Agenda Item 8 Medical Errors Task Force Report

Dr. Aristeiguieta reported a meeting with the Medical Errors Task Force and some of the stakeholders of medicine in California for information gathering is set for June 15, 2007. He stated defining exactly what a medical error is and what the Board wants to achieve are critical in determining the Board's appropriate role.

Agenda Item 9 Oral Argument Task Force Report

Mr. Zerunyan reported he and Dr. Aristeiguieta met with Board staff and representatives from the OAH to discuss the issues relating to the oral argument process. The task force proposed the creation of a regulation requiring the parties to file briefs with citations to the record that specifically support their argument, which will avoid the introduction of new evidence into the oral argument proceeding. Language with respect to the regulation will be drafted and presented to the Board at a future meeting.

Julie D'Angelo Fellmeth, Center for Public Interest Law and former Enforcement Monitor, suggested the Board include language requiring respondents who testify at oral arguments to be put under oath.

Agenda Item 10 Election of Officers

It was M/S (Duruisseau/Wender) to nominate the current panel of officers for another term. Motion carried unanimously.

Agenda Item 11 Agenda Items for July 2007 Division Meeting

- Discussion on Practice Monitoring Condition
- Discussion on Surgical or Procedural Deficiencies
- Federal and California Appellate Decisions Pertaining to Medical Marijuana
- Medical Errors Task Force Update

Agenda Item 12 Public Comment

Frank Lucido, M.D. stated he continues to provide medical cannabis evaluations. He stated he has developed safe and protective standards for patients and physicians. He stated the loss of the Angel Rache case at the Appellate and Supreme Courts has not had any impact on the protection provided to physicians under Prop. 215. He further provided Mr. Thornton with the 10th anniversary edition of *O'Shaughnessy's* for review and distribution to the DMQ.

Agenda Item 13 Adjournment

There being no further business, the meeting was adjourned at 9:20 a.m.

Cesar A. Aristeiguieta, M.D., F.A.C.E.P.
President

REFER TO YOUR

LEGISLATIVE PACKET

FOR DISCUSSION OF

2007 LEGISLATION

Sent under separate cover.

MEDICAL BOARD OF CALIFORNIA
Status of Pending Regulations

Subject	Current Status	Date Approved by Division	Date Notice Published by OAL	Date of Public Hearing	Date of Final Adoption	Date to DCA for Review *	Date to OAL for Review **	Date to Sec. of State
Licensing Special Programs for Foreign Trained Physicians	At DCA; submittal to OAL pending completion of the fees rulemaking (next item) to move both forward at same time	Text modified at hearing 2/2/07; no adverse comments received by close of public comment period (3/15/07), so adopted	12/8/06	2/2/07	2/2/07	4/6/07		
Licensing Special Programs for Foreign Trained Physicians-FEES	Awaiting Dept of Finance approval	No comments at public hearing 2/2/07, so adopted	12/8/06	2/2/07	2/2/07	4/6/07		
Non-substantive changes from all units (Section 100 changes)	Filed with Secretary of State	Since non-substantive changes, Divisions will not need to approve	publication not required	hearing not required	adoption not required	review by DCA not required	5/11/07	6/13/07
Physician Assistant Comm. (Section 100 changes)	At OAL	Since non-substantive changes, Divisions will not need to approve	publication not required	hearing not required	adoption not required	review by DCA not required	5/26/07	
Non-substantive changes from all units (Section 100 changes)	Next review of MBC regulations pending Fall 2007							

* - DCA is allowed 30 calendar days for review
** - OAL is allowed 30 working days for review

Prepared by Kevin A. Schunke
Updated July 6, 2007
For questions, call (916) 263-2368

State of California Department of Consumer Affairs

Medical Board of California

Agenda Item 5

July 16, 2007

TO: Members
Division of Medical Quality

FROM: Kimberly Kirchmeyer, Deputy Director

SUBJECT: Oral Argument Process

In the Enforcement Monitor's Report, Julie D'Angelo Fellmeth, the Board's Enforcement Monitor, recommended that the Medical Board of California (MBC) should discuss the value of the Division of Medical Quality's (DMQ) review of Administrative Law Judge's (ALJ) decisions. One aspect of this recommendation was that the oral argument process was flawed. The overall message was that the DMQ should eliminate or reform the oral argument process. Some issues of concern, from her perspective were that the arguments are not confined to the evidence in the record and the ALJ is not the same judge present at the original hearing so he/she cannot ensure new evidence is not entered into the record; the respondent is given the opportunity to address the panel, though not under oath; the DMQ panel is not present at the hearing and are not judges, but they are allowed to "second guess" the findings of a qualified judge; and the client (DMQ) hears argument from its own counsel (Deputy Attorney General).

Based upon this recommendation, the issue of the DMQ's review of decisions was part of the discussions regarding the MBC restructuring. Although consensus was reached on changing the review process of decisions (i.e. default decisions and stipulations for surrender of license will not be forwarded to the DMQ panels for review), there was not a decision reached on how to restructure the oral argument process. Therefore, a two-member committee, Cesar Aristeiguieta, M.D. and Frank Zerunyan, J.D., was appointed to review and discuss this issue and develop a recommendation.

Dr. Aristeiguieta and Mr. Zerunyan met to discuss recommendations developed by staff. They also met with an ALJ to obtain their input into the process and any assistance they could provide on recommended changes to the process. After discussion and consideration, the committee has determined that at this time the MBC should try to enhance the oral argument process, rather than abolish it. In an effort to do that, the attached regulations have been drafted to 1) require the respondent to be placed under oath if they address the panel, 2) authorize the ALJ or a panel member to request a party support their oral argument by citation to the record, and 3) places specific requirements on the written argument.

The committee is asking the DMQ to review this amended and new regulation language and make a motion to allow staff to move forward in setting a regulatory hearing at the November board meeting.

1364.30 Procedures for the Conduct of Oral Argument

(a) A party who wishes to present oral argument to the panel of the division that issued an order of nonadoption or reconsideration shall make a written request for oral argument not later than twenty (20) calendar days after the date of the notice of nonadoption or the order granting reconsideration.

(b) An administrative law judge will preside at oral argument. The administrative law judge may sit with and assist the panel members with their closed session deliberations.

(c) The arguments shall be based only on the existing record and shall not exceed the scope of the record of duly admitted evidence. No new evidence will be heard. The panel members may ask questions of the parties to clarify the arguments, but may not ask questions that would elicit new evidence. The administrative law judge and any panel member may ask a party to support the party's oral argument on a matter with a specific citation to the record.

(d) The administrative law judge shall stop an attorney, a party, or a panel member if the line of questioning or argument is beyond the record or is otherwise out of order.

(e) The administrative law judge shall offer the respondent an opportunity to address the panel regarding the penalty. If the respondent elects to address the panel, the administrative law judge shall place the respondent under oath.

(f) The sequence of, and time limitations on, oral argument are as follows:

(1) First -the respondent licensee and/or his or her legal counsel, who shall be limited to fifteen minutes.

(2) Second -the deputy attorney general, who shall be limited to fifteen minutes.

(3) Third -the respondent licensee's rebuttal or that of his or her legal counsel, which shall be limited to five minutes.

(4) Fourth -the deputy attorney general, who shall be limited to five minutes.

NOTE: Authority cited: Sections 2018 and 2336, Business and Professions Code. Reference: Section 2336, Business and Professions Code.

1364.32 Written Argument Submitted in Response to an Order of Nonadoption or Reconsideration

(a) Written argument submitted in response to an order of nonadoption or reconsideration shall:

(1) State each point under a separate heading or subheading summarizing the point and support each point by argument, and citation of authority if applicable; and

(2) Support any reference to a matter in the record by a citation to the volume and page number of the record or exhibit number where the matter appears.

NOTE: Authority cited: Sections 2018 and 2336, Business and Professions Code. Reference: Section 2336, Business and Professions Code.

State of California Department of Consumer Affairs

Memorandum

To: Renée Threadgill, Chief of Enforcement
Medical Board of California

Date: July 1, 2007

Agenda Item 6-A

From: Susan Goetzinger
Expert Reviewer Program

Subject: Results of the Expert Survey Questionnaires

Questionnaires Sent this quarter (April 1-June 30, 2007)	20
Feedback Received from the questionnaires sent this quarter	13 (65%)
Total Feedback Received for this quarter's report	17

Questions 1-8, *positive response*: Yes
Question 9, *positive response*: No
Questions 10-13, *positive response*: Yes

1	Were you provided sufficient information/evidence to allow you to render a medical opinion?	94 percent YES 6 percent - Yes & No
2	Were you encouraged to render an unbiased opinion?	100 percent YES
3	Was the case directly related to your field of expertise?	100 percent YES
4	Were you given sufficient time to review the case?	100 percent YES
5	Did the training material provided to you (the Expert Reviewer Guidelines and videotape/DVD) give you adequate information to perform your case review?	100 percent YES
6	Were you given clear, concise, and easy to follow instructions throughout the process?	100 percent YES
7	Was the investigator and/or MBC staff readily available to answer questions or concerns about the case?	82 percent YES 18 percent responded N/A
8	Is the required written report adequate to cover all aspects of your opinion?	94 percent YES 6 percent NO
9	Do you feel the MBC has requested your services more frequently than you would prefer?	100 percent NO
10	Would you be willing to accept more MBC cases for review?	94 percent YES 6 percent MAYBE
11	If you were required to testify, was the Deputy Attorney General readily available to answer questions and provide direction?	12 percent YES 88 percent N/A
12	**Do you feel the reimbursement amount for case review is appropriate for the work you are required to perform?**	58 percent YES 42 percent NO

13	**Do you think that more physicians would be willing to become experts if the Board offered CME in addition to monetary compensation**?	47 percent YES 41 percent NO 6 percent responded N/A 6 percent MAYBE
Level of satisfaction with overall experience performing case reviews for MBC		88 percent HIGH 6 percent Above Average 6 percent AVERAGE

SUGGESTIONS FOR IMPROVEMENT TO THE PROGRAM

The interviews of the physicians can be very insightful but it would be more so if the questions were tailored by a consultant. For example thoracic surgeon investigated. Case reviewed 1st (preliminary), then for audio interview specific speciality questions posed by expert Thoracic Surgeon, would increase the insightfulness of the questions.
Perhaps a better understanding of the implication of what we say as to how it may affect the doctor's career or reputation. I wasn't aware that the case could be closed or monitored depending on our opinions.

COMMENTS REGARDING REIMBURSEMENTS/CME

Re-compensation - I realize fiscal concerns for MBC are an issue; but if MBC needs to attract more quality reviewers, they may need to increase their compensation.
I think that CME is not the main incentive for these reviews. I believe that more financial compensation (hourly rate) would bring more experts in the program.
The reimbursement rate is just not adequate.
I do not think that CME credits will make any difference.
More physicians would be willing to do reviews if pay increased, but not necessarily CME. However, CME would be nice.
Reimbursement is very low. Reimbursement forms (hours by specific dates) are a burden). Writing report is very time consuming. I am still waiting for my reimbursement pay on time & with less paperwork!
More unusual or more difficult cases may honestly require more hours. I found myself 'under reporting' hours for this case because I was acutely aware of the 'cap.' Most reviewers would <u>not</u> do this and if they felt so constrained, they either would not accept another case, or go short on the research needed to be done. Most people I know practicing as consultants - integrative medicine providers can not afford or will not choose to spend their time for so little reimbursement (usual rate/hr $250-500 for most qualified individuals). I consider this as a public service and so agree to spend some of my time this way for so little reimbursement.

Normal charge is $300/hr.
Compensation is on low side compared to rates for expert review in medical legal cases. Compensation is about 1/3 to1/2 of other types of expert review.

GENERAL COMMENTS

Interested in reviewing more cases.
Wonderful program!
Staff at San Diego office extremely nice & helpful!!
Given the apparent gap in the law (i.e., basic record-keeping requirements for unlicensed healthcare providers) in cases such as this - the option of being able to be present (and especially if able to ask questions of the subject) at the interview would be very helpful in this case. [Reviewed a homeopathic/unlicensed case] "It would be nice to know if the issues re-the law in such cases was even being considered at this time so the public could be more protected from such individual's practices that may put them in harm's way."

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE EXPERTS BY SPECIALTY
CALENDAR YEAR 2007 (JAN - JUNE)

Agenda Item 6-B

SPECIALTY	# OF CASES SENT TO EXPERTS	# OF EXPERTS USED & HOW OFTEN	ACTIVE EXPERTS (TOTAL=1,066)
ADDICTION (ASAM NON-ABMS)	0	0	13
AEROSPACE MED.	0	0	1
ALLERGY & IMMUNOLOGY	1	1 Expert reviewed 1 case	10
ANESTHESIOLOGY	6	6 Experts reviewed 6 cases	84
COMPLEMENTARY/ALTERNATIVE	3	1 Expert reviewed 1 case 1 Expert reviewed 2 cases	14
CORRECTIONAL HEALTHCARE	1	1 Expert reviewed 1 case	5
DERMATOLOGY	3	3 Expert reviewed 3 cases	10
EMERGENCY	5	3 Experts reviewed 1 case 1 Expert reviewed 2 cases	63
FAMILY	15	11 Experts reviewed 1 case 2 Experts reviewed 2 cases	94
HOSPICE & PALLIATIVE CARE	0	0	5
HYPERBARIC MEDICINE	0	0	1
INTERNAL GENERAL INTERNAL	22	15 Experts reviewed 1 case 1 Expert reviewed 3 cases* 1 Expert reviewed 4 cases*	219
INTERNAL - CARDIOLOGY	6	4 Experts reviewed 1 case 1 Expert reviewed 2 cases	25
INTERNAL - ENDOCRINOLOGY	0	0	8
INTERNAL - GASTROENTEROLOGY	4	2 Experts reviewed 1 case 1 Expert reviewed 2 cases	15
INTERNAL -INFECTIOUS DISEASES	1	1 Expert reviewed 1 case	4
INTERNAL - NEPHROLOGY	0	0	7
INTERNAL - ONCOLOGY	5	3 Experts reviewed 1 case 1 Expert reviewed 2 cases	8
MEDICAL GENETICS	0	0	1

* Database updated: Expert can not be used again until Jan 2008 - has reviewed maximum number of cases for year.

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE EXPERTS BY SPECIALTY
CALENDAR YEAR 2007 (JAN - JUNE)

MIDWIFE REVIEWER	1	1 Expert reviewed 1 case	12
NEUROLOGICAL SURGERY	2	2 Experts reviewed 1 case (1 Expert not on list)	10
NEUROLOGY	3	1 Expert reviewed 1 case 1 Expert reviewed 2 cases	20
NEUROLOGY (CHILD)	1	1 Expert reviewed 1 case	2
OBSTETRICS & GYNECOLOGY	25	(1Expert not on list- reproductive endocrinology) reviewed 2 cases 12 Experts reviewed 1 case 1 Expert reviewed 2 cases 3 Experts reviewed 3-4 cases*	76
OCCUPATIONAL MED	0	0	8
OPHTHALMOLOGY	2	2 Experts reviewed 1 case	48
ORAL & MAXILLOFACIAL SURG	0	0	1
ORTHOPAEDIC SURGERY	9	9 Experts reviewed 1 case	43
OTOLARYNGOLOGY	5	5 Experts reviewed 1 case	34
PAIN MEDICINE	8	4 Experts reviewed 2 cases	23 [BD CERTIFIED-17]
PATHOLOGY	0	0	14
PEDIATRICS	2	2 Experts reviewed 1 case	57
PEDIATRIC CARDIOLOGY	1	1 Expert reviewed 1 case	3
PEDIATRIC HEMATOLOGY/ONCOLOGY	0	0	1
PEDIATRIC SURGERY	0	0	3
PHYSICAL MED & REHAB	0	0	8
FACIAL PLASTIC & RECONS. SURG	0	0	8
PLASTIC SURGERY	10	10 Experts reviewed 1 case	36
PSYCHIATRY	7	5 Experts reviewed 1 case 1 Expert reviewed 2 cases	114
PUBLIC HEALTH & GEN. PREVENTIVE MED	0	0	6

* Database updated: Expert can not be used again until Jan 2008 - has reviewed maximum number of cases for year.

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE EXPERTS BY SPECIALTY
CALENDAR YEAR 2007 (JAN - JUNE)
Page 3

DIAGNOSTIC RAD/ RADIOLOGY/NUCLEAR MED	2	2 Experts reviewed 1 case	38
RADIATION ONCOLOGY/ THERAPEUTIC RADIOLOGY	1	1 Expert reviewed 1case	3
SLEEP MEDICINE	0	0	1
SPINE SURGERY	0	0	1
SURGERY	4	4 Experts reviewed 1 case	56
COLON & RECTAL SURGERY	0	0	6
THORACIC SURGERY	2	2 Experts reviewed 1 case	16
VASCULAR SURGERY	1	1 Expert reviewed 1case	3
UROLOGY	3	3 Experts reviewed 1 case (1Expert not on list- Organ transplant)	17

/susan (6/4/07)

* Database updated: Expert can not be used again until Jan 2008 - has reviewed maximum number of cases for year.

EDMUND G. BROWN JR.
Attorney General

State of California
DEPARTMENT OF JUSTICE

455 GOLDEN GATE AVENUE, SUITE 11000
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Agenda Item 8

April 6, 2007

David T. Thornton
Executive Director
Medical Board of California
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236

RE: Review of Federal and California Appellate
Decisions Pertaining to Medical Marijuana

Dear Mr. Thornton:

Pursuant to your request, we have reviewed the current state of the law pertaining to physicians and medical marijuana.

I.
Factual Background
Re Medical Board Policy Statement
On Medical Marijuana

In 1996, California voters passed Proposition 215, the Compassionate Use Act. That Act is codified at Health and Safety Code section 11362.5. Over the next few years, there was confusion among physicians about their role in recommending marijuana to patients. The Medical Board published several statements designed to assist physicians in understanding their role in discussing and recommending marijuana to patients.

In May 2004, the Medical Board of California issued a detailed policy statement setting forth the Board's position. In essence, the policy statement clarified that physicians do not violate the standard of practice when they recommend marijuana to patients, as long as that recommendation is based upon sound principles of medical practice. The policy states that physicians who recommend or approve marijuana for medical use should follow the same

standards "as any reasonable and prudent physician would follow when recommending or approving any other medication, including the following:

1. History and good faith examination of the patient.
2. Development of a treatment plan with objectives.
3. Provision of informed consent including discussion of side effects.
4. Periodic review of the treatment's efficacy.
5. Consultation, as necessary.
6. Proper record keeping that supports the decision to recommend the use of medical marijuana."

II.

Analysis Of Federal And State
Cases Regarding Medical Marijuana

Since the Medical Board issued its policy statement, several cases have been decided by the courts on the broader issue of medical marijuana. While there have been no California state court cases which discuss in any significant way the obligations of the physician in recommending or approving marijuana for medical use, some recent federal court cases have at least mentioned the role of the physician.

Before discussing the recent decisions, however, it is useful to go back to the Ninth Circuit's decision in *Conant v. Walters* (2002) 309 F.3d 629. The *Conant* decision remains the pivotal case for defining the proper role of the physician. The Ninth Circuit concluded that California physicians have a First Amendment right to discuss and recommend the medical use of marijuana to patients, as long as that discussion and recommendation is made in the context of a bona fide physician-patient relationship and is based on sound medical judgment. The court described the role of the physician as that of a designated "gatekeeper" who bears the legal responsibility to make the determination whether the patient is seriously ill and that marijuana use will be limited to medical purposes. As the court observed at pg. 647:

> "[D]octors are performing their normal function as doctors and, in so doing, are determining who is exempt from punishment under state law. If a doctor abuses this privilege by recommending marijuana without examining the patient, without conducting tests, without considering the patient's medical history or without otherwise following standard medical procedures, he will run afoul of state as well as federal law. But doctors who recommend medical marijuana to patients after complying with accepted medical procedures are not acting as drug dealers; they are acting in their professional role in conformity with the standards of the state where they are licensed to practice medicine."

No subsequent cases have altered this well-reasoned and common-sense description of the physician's role and responsibility. In October, 2005, the United States Supreme Court issued its opinion in *Gonzales v. Raich* (2005) 545 U.S. 1. The Supreme Court decision essentially stands for the proposition that the federal government has the authority to regulate

marijuana under the Controlled Substances Act, even where the marijuana use is legally permissible under California law and is purely "local." The Supreme Court did not question the right of physicians to discuss or recommend marijuana. To the extent the role of the physician was addressed, it was only in passing, and specifically notes:

> "Moreover, the Medical Board of California has issued guidelines for physicians' cannabis recommendations, and it sanctions physicians who do not comply with the guidelines."
> (*Gonzales v. Raich, supra,* Thomas J. dissenting.)

In a decision issued in March, 2007, *Raich v. Gonzales*, the Ninth Circuit considered Ms. Raich's case on remand from the Supreme Court. Again, this decision mentions the role of the physician only in passing. There is nothing in the opinion that in any way undermines or questions the Medical Board's policy statement, or the guidelines set forth in the *Conant* decision.

III.
Conclusion:
The Medical Board's Policy Re Medical
Marijuana Is Not Impacted By Recent Case Law

Based upon the above review and analysis, there is no recent legal precedent which would require the Medical Board to revisit its previously issued policy statement on medical marijuana. We will continue to monitor new cases as they are issued by the courts, and will keep you advised of any new developments.

Sincerely,

JANE ZACK SIMON
LAWRENCE A. MERCER
Deputy Attorneys General

For EDMUND G. BROWN JR.
Attorney General

cc: Renee Threadgill, Chief of Enforcement
Carlos Ramirez, SAAG HQE
Jose R. Guerrero, SDAG

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STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
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MEMORANDUM

Agenda Item 9-A

Date: June 15, 2007

To: Members
Division of Medical Quality
Medical Board of California

From: Anita Scuri
Legal Affairs Division
Supervising Sr. Counsel

Re: **PROPOSED PRECEDENTIAL DECISION**
In the Matter of the Accusation Against Joseph J. Basile, M.D.
Case No. 03-2000-108170
OAH No. N2002050521

In accordance with the procedure adopted by the Division of Medical Quality in July 2004 (Exhibit 1), the Office of the Attorney General has recommended that portions of the above-captioned decision be designated as Precedential. The executive director, chief of enforcement and I all agree with this recommendation.

Procedural Background

Dr. Basile ("respondent") was the subject of an Accusation and several amendments thereto. The matter was heard before Administrative Law Judge Jonathan Lew, who submitted a Proposed Decision to the Division on July 16, 2004. The Division non-adopted that decision and remanded the matter to the administrative law judge for the taking of additional evidence on specified issues.

After the nonadoption and prior to the remand hearing, the parties reached a stipulated agreement, which was adopted by Panel A of the Division on May 18, 2006. That stipulated decision adopted the Proposed Decision of Administrative Law Judge Jonathan Lew except for paragraph 10 of the Legal Conclusions and the original Order at page 13 of the proposed decision. It increased the period of probation from 3 years to 4 years and struck the cost recovery order (the latter modification resulting from the change in law effective January 1, 2006 eliminating cost recovery by the board). Despite the matter having been resolved by stipulation, the Division's stipulated decision adopts the Proposed Decision and therefore its decision may be designated as Precedential since it resulted from a contested hearing.

Facts/Findings of the Case

The Accusation charged respondent with a variety of violations, all stemming from his involvement as "medical director" in a medical office called "The Vein & Cosmetic Enhancement Center" or "VCEC." VCEC was not a professional medical corporation owned by physicians but was instead a general law (nonprofessional) corporation wholly owned by respondent's wife. Respondent's wife is not a physician or any other type of licensed health care professional.

VCEC used lasers and intense pulsed light ("IPL") to treat varicose and spider veins. The details regarding the lasers are found at pages 2 and 3 of the Proposed Decision. Both respondent and his wife operated the IPL/lasers in providing medical treatment for varicose and spider veins. Respondent's wife used IPL/lasers to treat patient S.S. and that treatment caused burns and blisters on the legs of patient S.S., resulting in scarring.

The following legal conclusions of the administrative law judge are pertinent to the request to designate portions of the decision as a precedential decision:

1. Respondent's wife engaged in the unlicensed practice of medicine. She was the sole owner and sole corporate officer of VCEC and provided laser treatment to patients, which was the unlicensed practice of medicine. Even if respondent's wife qualified as a medical assistant, medical assistants may not legally perform IPL/laser treatments on patients.

2. Respondent aided and/or abetted the unlicensed practice of medicine by allowing respondent's wife to use the IPL/laser to treat patients.

Portions of Decision to be Designated as Precedential

The recommendation is that only the following portions of the decision be designated as precedential:

> Factual Findings -- 1 and 2; the first sentence of Factual Finding 3; Factual Findings 4 and 5; and Factual Finding 6 except for the last two sentences.
>
> Legal Conclusions -- 1 through 5.

For the sake of clarity, if the Division approves the request to designate the above portions of the decision as Precedential, I recommend that the Division use the same method as the courts use when granting partial publication of a decision. That is, those portions not accepted for publication are redacted and replaced with asterisks. To illustrate, I have attached as Exhibit 2 the decision in its entirety. Exhibit 3 is the redacted version of the decision. This is what those viewing the Division's precedent decisions would see.

Rationale

16 Cal. Code Regs. 1364.40(a) authorizes the division to designate, as a precedent decision, "any decision or part of any decision that contains a significant legal or policy determination of general application that is likely to recur."

Lasers are widely used as a means of treating many conditions—cosmetic and otherwise. This decision would clarify that unlicensed persons may not use IPL and/or lasers to treat medical conditions, that a medical assistant (who is an unlicensed person) may not legally perform IPL/laser treatments on patients, and that a general law corporation cannot legally practice medicine even if it hires a medical director. These are all issues which recur on a frequent basis. The portions of the decision proposed to be designated as precedent contain significant legal determinations and would provide guidance to physicians, their advisors, law enforcement agencies, and the general public as to who may own a medical practice and/or use IPL/lasers in treating medical conditions.

DOREATHEA JOHNSON
Deputy Director, Legal Affairs

ANITA L. SCURI
Supervising Sr. Counsel

Attachments

cc: Thomas Reilly, Deputy Attorney General

EXHIBIT 1

Memorandum

To : **Carlos Ramirez, Asst. DAG**
Tom Reilly, DAG
Mary Agnes Matyszewski, DAG
Health Quality Enforcement Section
Office of the Attorney General

Date: July 28, 2004

From : **Joan M. Jerzak**
Chief, Enforcement Program

Subject: **Precedential Decisions Revised Procedures**

As a follow-up to our meeting on July 21, 2004, with DCA Legal Counsel Anita Scuri, Board Counsel Nancy Vedera, Interim Executive Director Dave Thornton and me, the attached Precedent Decision Procedure was revised. I believe it incorporates all the offered suggestions and will serve as a guide for Board staff as decisions are selected for precedential designation.

Thank you all for your assistance.

PRECEDENT DECISION PROCEDURE

July 2004

Introduction

The purpose of this policy is to establish a procedure for identifying potential precedential decisions and reviewing and acting upon recommendations to designate decisions as precedential. Under the Administrative Procedure Act (APA) a decision that contains a significant legal or policy determination of general application that is likely to recur may be designated as precedential. (See Government Code (GC) Section 11425.60; Attachment 1) Once a decision is designated as precedential, the Division of Medical Quality (hereinafter "Division") may rely on it, and parties may cite to such decision in their argument to the Division and courts. Furthermore, it helps ensure consistency in decision-making by institutionalizing rulings that the Board feels reflects its position on various issues. The Division has adopted section 1364.40, Title 16, California Code of Regulations, to implement its authority to designate decisions as precedential.

Step 1: Identifying Potential Precedential Decisions

A decision or part of a decision that contains significant legal or policy determination of general application that is likely to recur may be recommended for designation as a precedential decision. Section 11425.60 does not preclude the Board from designating as precedential a decision that is already in effect. The recommendation shall be made to Board Counsel, giving the reasons why the person believes the decision meets the criteria to be designated as a precedential decision. Their recommendation shall be accompanied by a copy of the decision.

Step 2: Review of Recommendation

If the Executive Director, after consultation with the Chief of Enforcement and the Board Counsel, concludes that the Division should consider the decision for precedential designation, the matter will be placed on the Division's agenda for action. The agenda serves as public notice that the Division will consider the decision as a precedential decision.

Step 3: Preparation for Board Review

Board Counsel will then prepare or will arrange with the appropriate staff to prepare the precedential designation proposal for presentation to the Division for review and consideration.

The Board's Discipline Coordination Unit shall maintain a log of the decisions proposed to the Division for precedential designation. The log shall show the date of the Board meeting, decision number, respondent's name, a general description of the legal or policy issue, and whether the precedential decision was approved or not. A copy of the Board Counsel memorandum and minutes of the Board meeting (when the decision was discussed) will be maintained with the log.

If the Division adopts a decision as precedential, it will be assigned a precedential designation number. The precedential designation number shall begin with "MBC" and uses the calendar year and sequential numbering beginning with "01" for each year, followed by lettering for the Division designating the decision, DMQ (Division of Medical Quality) and DOL (Division of Licensing), (i.e., MBC-2004-01-DMQ for year 2004).

Step 4: Designation of a Precedential Decision

Board Counsel will prepare an order designating the decision, or portion(s) of the decision, as precedential for signature by the Division President. The effective date is the date the date the decision was designated as a precedential decision. (See Attachment 2 for an example of a Designation as Precedential Decision.)

Board Counsel will send a copy of the signed Designation as a Precedential Decision, including a copy of the decision, to the Office of Administrative Hearings. (The Office of Administrative Hearings maintains a file of precedential designations for reference by Administrative Law Judges.)

Step 5: Indexing

Under Government Code section 11425.60(c), the Division is required to maintain an index of significant legal and policy determinations made in precedential decisions. The Board's Discipline Coordination Unit will maintain the index.

The index shall be divided into three sections (Attachment 3) :

1) Decisions by fiscal year, including: the precedential designation number, the respondent's name, the MBC case number, the OAH case number and the precedential designation date (effective date).

2) Subject matter, followed by a general description of legal and/or policy issue, the precedential designation number and the respondent's name.

3) Code section number, followed by a general description of the section, the precedential designation number and the respondent's name.

NOTE: As decisions are added to the index, an asterisk will be entered after the cases, showing if they were appealed to the Superior Court, Court of Appeals or Supreme Court. Two asterisks following the case, will reflect the case was reversed as a precedential decision by the Board.

A copy of each precedential designation shall be maintained with the index and on the Board's website. The index shall be updated every time a decision is designated as precedential. The index is a public record, available for public inspection and copying. It shall be made available to the public by subscription and its availability shall be published annually in the California Regulatory Notice Register. Each January, Board staff will submit the index to the Office of Administrative Law for publication in the California Regulatory Notice Register.

Step 6: Reversal of Precedential Designation

The Executive Director, after consultation with the Chief of Enforcement and Board Counsel, may recommend that the Division reverse its designation of all or portion(s) of the precedential designation on a decision. The matter will then be placed on the agenda for action. Board Counsel will prepare or arrange with the appropriate staff to prepare the order, "Reversal of Precedential Designation," (Attachment 4). Board Counsel will then send a copy of the signed Reversal of Precedential Designation, including a copy of the decision to the Office of Administrative Hearings.

§ 11425.60. Decisions relied on as precedents

(a) A decision may not be expressly relied on as precedent unless it is designated as a precedent decision by the agency.

(b) An agency may designate as a precedent decision a decision or part of a decision that contains a significant legal or policy determination of general application that is likely to recur. Designation of a decision or part of a decision as a precedent decision is not rulemaking and need not be done under Chapter 3.5 (commencing with Section 11340). An agency's designation of a decision or part of a decision, or failure to designate a decision or part of a decision, as a precedent decision is not subject to judicial review.

(c) An agency shall maintain an index of significant legal and policy determinations made in precedent decisions. The index shall be updated not less frequently than annually, unless no precedent decision has been designated since the last preceding update. The index shall be made available to the public by subscription, and its availability shall be publicized annually in the California Regulatory Notice Register.

(d) This section applies to decisions issued on or after July 1, 1997. Nothing in this section precludes an agency from designating and indexing as a precedent decision a decision issued before July 1, 1997.

HISTORY:

Added Stats 1995 ch 938 §21 (SB 523), operative July 1, 1997; Amended by Stats 1996 ch 390 §8 (SB 794), operative July 1, 1997.

Added "and indexing" in subd (d).

Law Revision Commission Comments:

1995_Section 11425.60 limits the authority of an agency to rely on previous decisions unless the decisions have been publicly announced as precedential.

The first sentence of subdivision (b) recognizes the need of agencies to be able to make law and policy through adjudication as well as through rulemaking. It codifies the practice of a number of agencies to designate important decisions as precedential. See Sections 12935(h) (Fair Employment and Housing Commission), 19582.5 (State Personnel Board); Unemp. Ins. Code 409 (Unemployment Insurance Appeals Board). Section 11425.60 is intended to encourage agencies to articulate what they are doing when they make new law or policy in an adjudicative decision. An agency may not by precedent decision revise or amend an existing regulation or adopt a rule that has no adequate legislative basis.

Under the second sentence of subdivision (b), this section applies notwithstanding Section 11340.5 ("underground regulations"). See 1993 OAL Det. No. 1 (determination by Office of Administrative Law that agency designation of decision as precedential violates former Government Code Section 11347.5 [now 11340.5] unless made pursuant to rulemaking procedures). The provision is drawn from Government Code Section 19582.5 (expressly exempting the State Personnel Board's precedent decision designations from rulemaking procedures). See also Unemp. Ins. Code 409 (Unemployment Insurance Appeals Board). Nonetheless, agencies are encouraged to express precedent decisions in the form of regulations, to the extent practicable.

The index required by subdivision (c) is a public record, available for public inspection and copying.

Subdivision (d) minimizes the potential burden on agencies by making the precedent decision requirements prospective only.

Attachment 1

SAMPLE

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: NAME	)	OAH No.
	)	MBC Case No.
Physician's and Surgeon's Certificate No.	)	PRECEDENTIAL DECISION No. MBC-2004-01-DMQ
Respondent.	)	

DESIGNATION AS A PRECEDENTIAL DECISION

Pursuant to Government Code Section 11425.60, the Division of Medical Quality, Medical Board of California, hereby designates as precedential Decision No. MBC-2004-01-DMQ (or those sections of the decision listed below) in the Matter of the Accusation Against NAME.

1) Findings of Fact Nos. 3-6; and
2) Determination of Issues No. 5.

This precedential designation shall be effective July 30, 2004.

LORIE RICE, President
Division of Medical Quality
Medical Board of California

Attachment 2

SAMPLE

2004

Medical Board of California
Precedential Decisions

Index

MBC-2004-01-DMQ ***Ridgill, Edward***, MBC Case No. 06-1997-78021, OAH Number E-123545, July 30, 2004

Attachment 3
1 of 2 pages

SAMPLE

Medical Board of California
Precedential Decisions

Index 2004

by Subject Matter

Petition for Penalty Relief
Evidence of rehabilitation, or lack of, 2004-01-DMQ

Rehabilitation
Petitioner's burden, 2004-01-DMQ

by Code Section

Business and Professions Code

Section 2307 - Modification or Termination of Probation –
2004-01-DMQ, *Ridgill*

2 of 2 pages

SAMPLE

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: NAME	)	OAH No.
	)	MBC Case No.
Physician's and Surgeon's Certificate No.	)	PRECEDENTIAL DECISION No. MBC-2004-01-DMQ
Respondent.	)	

WITHDRAWAL OF PRECEDENTIAL DECISION

Pursuant to Government Code Section 11425.60, the Division of Medical Quality, Medical Board of California, hereby orders the withdrawal of precedential Decision No. DMQ-2004-01-DMQ (or those sections of the decision listed below) in the Matter of the Accusation Against NAME.

1) Findings of Fact Nos. 3-6; and
2) Determination of Issues No. 5.

The withdrawal of this precedential designation shall be effective July 30, 2005.

LORIE RICE, President
Division of Medical Quality
Medical Board of California

Attachment 4

EXHIBIT 2

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	
	)	
JOSEPH F. BASILE, M.D.	)	**File No. 03-2000-108170**
	)	
Physician's and Surgeon's Certificate No. G74601	)	
	)	
	)	
Respondent.	)	
	)	

DECISION

The attached Stipulated Settlement and Waiver is hereby adopted as the Decision and Order of the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on June 19, 2006.

IT IS SO ORDERED May 18, 2006.

MEDICAL BOARD OF CALIFORNIA

By _____

Steven Alexander, Chair
Panel A
Division of Medical Quality

BILL LOCKYER, Attorney General
of the State of California
VIVIEN H. HARA
Supervising Deputy Attorney General
JOSE R. GUERRERO
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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: JOSEPH F. BASILE, M.D. 130 Coffee Road, Suite 7 Modesto, CA 95355 Physician's and Surgeon's Certificate No. G74601 Respondent.	Case No. 03-2000-108170 OAH No. N2002050521 **STIPULATED SETTLEMENT AND WAIVER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Ron Joseph (Complainant) was the Executive Director of the Medical Board of California when this action commenced. Currently, David T. Thornton, is the Executive Director. This action was brought solely in their official capacities. Complainant in this matter is represented by Bill Lockyer, Attorney General of the State of California, by Jose R. Guerrero, Deputy Attorney General.

2. Respondent Joseph F. Basile, M.D., (Respondent), is represented in this proceeding by attorney Robert B. Zaro, Esq., whose address is 915 L Street, Suite 1240, Sacramento, CA 95814.

3. On July 9, 1992, the Medical Board of California issued Physician's and Surgeon's Certificate No. G74601 to Joseph F. Basile, M.D. (Respondent). The Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 03-2000-108170 and will expire on May 31, 2006.

JURISDICTION

4. Accusation No. 03-2000-108170 was filed before the Division of Medical Quality (Division) for the Medical Board of California, Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on March 22, 2002. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 03-2000-108170 is attached as Exhibit A and incorporated herein by reference. A proposed written decision by Administrative Law Judge, Jonathan Lew was submitted to the Board on August 3, 2004 for its adoption and/or rejection. On August 3, 2004 the Board sent a Notice of Non-Adoption of Proposed Decision to the parties. On November 22, 2004 the Board issued its Order of Remand to the Administrative Law Judge, ordering the taking of additional evidence on solely two issues. The remand hearing was scheduled to begin on March 8, 2005.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 03-2000-108170. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

8. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Division's imposition of discipline as set forth in the Disciplinary Order below.

CONTINGENCY

9. This stipulation shall be subject to approval by the Division of Medical Quality. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Division regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Division considers and acts upon it. If the Division fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Division shall not be disqualified from further action by having considered this matter.

10. The parties understand and agree that facsimile copies of this Stipulated Settlement and Disciplinary Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

11. In consideration of the foregoing admissions and stipulations, the parties agree that the Division may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

THE BOARD HEREBY ADOPTS the proposed written decision of Administrative Law Judge, Jonathan Lew, attached hereto as Exhibit B, except for paragraph 10 (ten) of the legal conclusions which sets forth the penalty and the original Penalty Order at page 13 of the written proposed decision. THE PENALTY IS HEREBY INCREASED BY AN

ADDITIONAL ONE YEAR. IT IS THEREFORE ORDERED that Physician's and Surgeon's Certificate No. G74601 issued to Respondent Joseph F. Basile, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years on the following terms and conditions:

STANDARD CONDITIONS

1. NOTIFICATION Prior to engaging in the practice of medicine the respondent shall provide a true copy of the Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days. This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

2. SUPERVISION OF PHYSICIAN ASSISTANTS During probation, respondent is prohibited from supervising physician assistants.

3. OBEY ALL LAWS Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

4. QUARTERLY DECLARATIONS Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than ten (10) calendar days after the end of the preceding quarter.

5. PROBATION UNIT COMPLIANCE Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a Post Office Box serve as an address of record, except as allowed by Business and Professions Code

section 2021(b).

Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Division or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

6. INTERVIEW WITH THE DIVISION, OR ITS DESIGNEE Respondent shall be available in person for interviews at respondent's place of business or at the probation unit office, with the Division or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

7. RESIDING OR PRACTICING OUT OF STATE In the event respondent should leave the State of California to reside or to practice respondent shall notify the Division or its designee in writing within thirty (30) calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty (30) calendar days in which respondent is not engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and Probation Unit Compliance.

Respondent's license shall be automatically canceled if respondent's periods of temporary or permanent residence or practice outside California totals two years. However,

respondent's license shall not be canceled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

8. FAILURE TO PRACTICE MEDICINE-CALIFORNIA RESIDENT In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Division or its designee in writing within thirty (30) calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty (30) calendar days in which the respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically canceled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

9. VIOLATION OF PROBATION Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

10. COST RECOVERY Within 90 (ninety) calendar days from the effective

date of the Decision or the other period agreed to by the Division or its designee, respondent shall reimburse the Division the amount of $4,000 (four thousand dollars) for its investigative and prosecution costs. The filing of bankruptcy or period of non-practice by respondent shall not relieve respondent his obligation to reimburse the Division for its costs.

11. LICENSE SURRENDER Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within fifteen (15) calendar days deliver respondent's wallet and wall certificate to the Division or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

12. PROBATION MONITORING COSTS Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within thirty (30) calendar days of the due date shall constitute a violation of probation.

13. COMPLETION OF PROBATION Respondent shall comply with all financial obligations (probation costs, etc.) no later than one hundred twenty (120) calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Robert B. Zaro, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Division of Medical Quality, Medical Board of California.

DATED: January 10, 2006

Joseph F. Basile

JOSEPH F. BASILE, M.D.
Respondent

I have read and fully discussed with Respondent Joseph F. Basile, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: Jan 10, 2006

Robert B. Zaro

ROBERT B. ZARO
Attorney for Respondent

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EXHIBIT B

Administrative Law Judge Jonathan Lew's Proposed Decision

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: JOSEPH F. BASILE, M.D. 130 Coffee Road, Suite 7 Modesto, California 95355 Physician and Surgeon's Certificate No. G 74601 Respondent.	Case No. 03-2000-108170 OAH No. N2002050521

PROPOSED DECISION

This matter was heard before Administrative Law Judge Jonathan Lew, State of California, Office of Administrative Hearings on May 24 through 27, and June 16, 2004, in Oakland, California.

Jose R. Guerrero, Deputy Attorney General, represented complainant.

Robert B. Zaro, Esq., represented Joseph F. Basile, M.D., who was present.

The case was submitted for decision on June 16, 2004.

FACTUAL FINDINGS

1. Complainant Ronald Joseph was formerly the Executive Director of the Medical Board of California (Board). The Accusation and First and Second Amended Accusations were issued by him in his official capacity.

2. On July 9, 1992, the Board issued Joseph F. Basile, M.D. (respondent) Physician and Surgeon's Certificate No. G 74601. The certificate was current at all times pertinent to this matter. It was due to expire on May 31, 2004, if not renewed. There has been no prior disciplinary action taken against this certificate.

3. The allegations against respondent arise from his involvement in and operation of a medical office called "The Vein & Cosmetic Enhancement Center" (VCEC).

Complainant contends that respondent engaged in general unprofessional conduct, that he aided and abetted the unlicensed practice of medicine, that he failed to maintain adequate and accurate medical records, that he made false statements and was dishonest, and that he engaged in advertising without the use of his own name and/or without a fictitious name permit issued by the Board.[1] Respondent acknowledges his error in failing to obtain a fictitious name permit from the Board as required. He contests all other allegations made against him.

4. Professional Background. Respondent attended Georgetown University School of Medicine, graduating in 1987. He completed a portion of his residency at Georgetown University before transferring to St. Francis Hospital, affiliated with the University of Connecticut. Respondent became board certified in general surgery in April 1996. Between 1992 and 1999 he was on the medical staff of Salinas Surgery Center in Salinas, California. He also associated with the Monterey Peninsula Surgery Center. He describes his work in Salinas as a "bread and butter general surgery practice" involving hernia repairs, gall bladder, blunt trauma, cancers of all sorts and gastrointestinal surgery. Respondent also served as the medical director of VCEC, a business wholly owned by his wife, Vina Basile. She is neither a physician nor a nurse and she holds no other health profession licenses. VCEC was located in Carmel. Respondent relocated his medical practice to Modesto, where he worked for a short time with the Stanislaus County Health Services Agency. Vina Basile remained behind and continued to work in the Carmel VCEC office for a period before that office was closed in March 2001. VCEC moved to Modesto and respondent continued there in his position as its medical director.

5. PhotoDerm Vasculight Machine. Much of this case revolves around the use of a medical device known as a PhotoDerm Vasculight machine. In 1998, respondent became interested in new equipment that could be used for certain cosmetic procedures in a medical office setting. He leased a PhotoDerm Vasculight machine from a company called ESC Medical Systems, and this machine was delivered to his Salinas office in September or October 1998. The PhotoDerm Vasculight machine was designed for the treatment/removal of pigmented lesions, varicose veins, spider veins, reticular veins, age spots and hair. It works on the principle of light selectively being absorbed into pigment and then being converted into heat energy. The heat induces photocoagulation of blood vessels, a mild thermal destruction, without actually bursting the vessels. The body apparently repairs this damage and absorbs the damaged vein. This process causes the vein or cosmetic blemishes to fade. The concept and technology were developed and tested through the early 1990s, and approved by the Food and Drug Administration in early 1994. It is viewed as a relatively safe and non-invasive alternative to previous modes of removing blemishes. For example, one alternative, sclerotherapy, requires injection of an irritating solution to destroy the inner lining of veins, causing clotting and spasm. The new technology eliminated the need for sclerotherapy for most patients.

[1] Seven causes for disciplinary action were pled in the Second Amended Accusation. Complainant dismissed the third cause (Unlicensed Corporate Practice of Medicine) and the sixth cause (Conspiracy With Unlicensed Person) at the time of hearing.

There are other light emitting devices on the market similar to the one manufactured by ESC Medical Systems. However, the PhotoDerm Vasculight machine is unique in that it combines two light components into a single unit. The PhotoDerm component emits intense pulse light (IPL) through a hand piece, 5 to 15 mm wide. Filters are used to vary the wavelength of light emitted and this will affect the degree of skin penetration. For example, shorter wavelengths (550 nanometers (nm)) will penetrate 1 – 2 mm, and longer wavelengths (near the infrared spectrum) will penetrate 4 – 6 mm. The amount or dose of light delivered per surface unit area is called fluence, and it is measured in joules per square centimeter (J/cm^2). The duration and number of pulses can also be varied. The operator may input these several parameters into a computer software program that allows for individualized settings. Patients are typically categorized according to a Fitzpatrick skin type scale that incorporates their responses to a questionnaire on genetic disposition, reaction to sun exposure and tanning habits. The resulting Fitzpatrick scaled score (Skin Types I – VI) will guide the operator in making appropriate settings. The PhotoDerm or IPL component is particularly effective for treating the small varicose and "spider veins."

The second component (Vasculight) is essentially a laser. It is a single very long wavelength (1064 nm) of light amplified by reflecting mirrors. The beam from the laser hand piece is relatively small (4 mm circle) and because it emits a stronger and more coherent light beam it can be used effectively to treat larger veins. The Photoderm Vasculight machine operator can alternate between IPL or laser settings. The machine itself can also provide the operator with recommended settings based on the patient's skin type and the type of lesion (small, medium or deep) that is being treated. The operator may accept these settings or enter different ones. When the treatment is completed, information about each patient's treatment is stored in the machine's computer and can be retrieved later and printed at any time. These records contain patient identifying information, skin type, date and site of treatment, and the settings/figures for wavelength, fluence, pulse duration and number. The operator can also type narrative information under sections describing "Immediate response" and "Note."

6. Respondent and Vina Basile both received training on the operation and use of the PhotoDerm Vasculight from the manufacturer. Both operated the machine. Vina Basile was VCEC's only officer and sole shareholder. Respondent was a non-salaried employee of VCEC. His duties as the corporation's medical director were to obtain patient histories, conduct physical examinations and determine whether individuals were viable candidates for cosmetic procedures. After obtaining the patient's Fitzpatrick skin typing he would determine the appropriate IPL or laser settings for patients. Respondent also had sole responsibility for preparing and submitting patient medical evaluations and for setting fees. There were times when Vina Basile used the machine on patients without respondent also being present. Respondent would be available to her at those times by telephone or pager so that she could discuss any patient treatment matters with him. After VCEC moved to Modesto, Vina Basile ceased providing PhotoDerm Vasculight treatment to patients. Respondent and VCEC opted instead to hire registered nurses to operate the machine.

7. Respondent did not apply for nor did he receive a fictitious name permit from the Board to use the name "Vein and Cosmetic Enhancement Center." He did file a fictitious business name statement with the Monterey County Clerk for "The Vein & Cosmetic Enhancement Center of Monterey" on December 23, 1998. Respondent was unaware of the requirement that he also have a fictitious name permit issued by the Board and he apparently complied with Board requirements when made aware of his obligation. There was no evidence that patients were unaware of respondent's involvement or affiliation with VCEC. His name was prominently featured on a brochure detailing information about VCEC. His name also appeared on a separate VCEC list of fees for different services.

Patient S.S.

8. Patient S.S. came to VCEC on February 19, 1999, to inquire about treatment/removal of varicose veins for aesthetic reasons. She met with both respondent and Vina Basile. She was shown a video about the PhotoDerm Vasculight treatment and decided to go forward with the procedure. Her Fitzpatrick Skin Type was determined to be category III and a test strip was run to confirm that her skin would respond to treatment. On February 20, she was provided with an informed consent form which she reviewed and signed. The form specified: "I understand that there is a possibility of rare side effects such as scarring and permanent discoloration, as well as short term effects such as reddening, mild burning, temporary unsightly bruising, and temporary discoloration of skin." Her first treatment was on February 20, 1999. Patient S.S. received laser and IPL treatment that day on the front and back of her legs. Respondent set the fluence at 125.2 J/cm^2 and the pulse duration at 8.5. Respondent and Vina Basile were both present during the procedure. Notes for that treatment indicate "Cat-scratch effect present throughout" which was the desired result. A second appointment was scheduled for patient S.S. for March 19, 1999, for additional treatment. It is usual to wait 4 – 6 weeks between treatments.

Patient S.S. returned on March 19. Records for that date indicate that she was treated with the laser on the front of both legs. There is a handwritten notation by respondent that she had developed blisters on the previous treatment. Respondent reduced the fluence to 112 J/cm^2 and increased the pulse duration to 10. He made these adjustments in response to her comments about blistering. The resulting change reduced the impact upon her blood vessels by at least 25 percent, an appropriate adjustment in her case.

Patient S.S. was also treated on March 22, 1999, this time on the back of her legs. The laser settings were identical to that used on March 19. She experienced severe pain and was told that it was because the back of her legs were more sensitive. She endured the pain until it became too much and she then asked to have the procedure stopped. Respondent avers that he provided the treatment for patient S.S. on March 22. As a result of that treatment patient S.S. was blistered and burned on the back of both legs. Three other patients were burned that same day, including Vina Basile. Respondent contacted the manufacturer to complain. Representatives of ESC Medical Systems came to the office on May 6, 1999. Respondent called patient S.S. to see if she could join them and show her injuries to the representatives. Respondent was advised that there were two incompatible software versions

within the machine's computer. A loaner machine was provided to him and the PhotoDerm Vasculight machine was removed, repaired and returned. There have been no similar problems with the machine since. It does appear that the problems that occurred on March 22, 1999, were attributable solely to machine malfunction. There was no evidence of operator error. The settings used for patient S.S. were entirely appropriate.

9. Patient S.S. believes she was burned on March 19, 1999, and she has no recollection of being treated on March 22. She believes Vina Basile was the clinician at the time that she was burned. Patient S.S. was contacted by a VCEC employee, Ronnie, on March 25, 1999. He noted in her records that she reported being burned and blistered on all areas treated and that she was very upset. On April 21, 1999, respondent prescribed Keflex, 500 mg, for her wounds. She was advised that the redness of her burns, but not the scarring, could be minimized by additional IPL treatment. Vena Basile was involved in this aspect of her IPL treatment. Patient S.S. received IPL treatment on June 4, and again on July 16 and 28, 1999. Respondent also performed sclerotherapy on both of patient S.S.'s lower extremities on July 16, 1999. The final IPL treatment was on August 26, 1999. Both respondent and Vena Basile were involved.

10. On October 17, 2000, patient S.S. appeared in Monterey County Superior Court, Small Claims Division (Case No. MAR 115369) seeking compensation for the burns received during her treatment with respondent. Respondent submitted a declaration that he signed under penalty of perjury in which he stated: "Vina Basile, my spouse, is employed by me as the office manager and technician. Mrs. Basile is a trained technician and administers Photoderm ®PL to patients for treatment of vascular lesions. Mrs. Basile administered Photoderm ®PL to plaintiff [patient S.S.] on each of the six occasions when plaintiff underwent the treatment, including the March 22, 1999 session that plaintiff claims left her with burns."

11. On November 2, 2000, the Monterey County Medical Society sent respondent a letter advising him that only licensed individuals could treat patients with an IPL device. Respondent sought legal counsel on this issue and was led to believe that it was just one opinion in what was still a gray area. He avers that he had also called the Board earlier in January 1999, and that he was advised at that time that there were no regulations governing this area. By February 2001, he determined to close the Carmel VCEC office and have Vina Basile cease further treatment of patients. He arranged to have a registered nurse operate the machine after it was moved to Modesto. He decided not to hire a registered nurse while VCEC was still in Carmel because he knew that he would soon be moving the office to Modesto.

Dishonesty/Making False Statements/General Unprofessional Conduct

12. Complainant contends that respondent engaged in dishonest and corrupt practices when he signed a declaration under penalty of perjury in the Monterey County Small Claims Court indicating that Vina Basile performed all treatments on patient S.S. Complainant also believes that respondent made false entries into the medical records for

patient S.S. when he made a handwritten entry for March 19, 1999, that she had developed blisters during her previous treatment. This entry was not signed or dated. And complainant contends that respondent made a false entry in patient S.S.'s medical records indicating that she had been treated on March 22, 1999.

These allegations were not supported by the evidence. The declaration submitted in small claims court was drafted by an attorney retained by respondent and given to him for review and signature at the time of the small claims hearing. Respondent avers that he did not review it carefully before he signed it and that he was not aware that it stated that Vina Basile, and not respondent, had treated patient S.S. He points out that the issue in the small claims action had nothing to do with who treated patient S.S. Rather, the small claims case was based on negligence theory and respondent's defense was that injury to patient S.S. was caused by equipment malfunction and not by any treatment that fell below the standard of care. His defense had nothing to do with who treated patient S.S. and he had no apparent motive at that time to make a false statement about his involvement, or lack of involvement, in her care. The error was not material to the small claims court action. Respondent consistently stated during the Board's investigation, and also at hearing, that he treated patient S.S. at the time she was burned. It does not appear that respondent knew that the declaration that he signed was false when he signed it. Even if he was careless or should have known that the declaration was inaccurate, allegations relating to dishonesty and the making of false statements must be supported by evidence that the person knew that the statements were false when made. Complainant has not met this burden.

13. It was not established that respondent's handwritten entry into the computer generated records for patient S.S.'s March 19, 1999 treatment constituted dishonesty or the making of false statements. Respondent wrote on that date that patient S.S. had developed blisters on the previous treatment. His comments related back to her February 20, 1999 treatment. Better practice would be for him to have also signed and dated his notations by hand, but his failure to do so does not mean that he was dishonest or that he made false statements. On March 19, 1999, respondent did reduce the fluence from 125.2 to 112.0 J/cm^2, and he increased the pulse duration from 8.5 to 10. These actions were in apparent response to information reported to him from patient S.S. Her developing blisters during her previous treatment would have prompted such adjustments. Respondent explains that he handwrote the entry in the box reserved for notes during her March 19, 1999 treatment. He did not feel it was necessary to also initial or date his notes. His handwriting was recognizable to all in his office. Respondent provided a copy of patient S.S.'s records to her at her request. Her copy did not contain these handwritten notes. Respondent explains that this was because she was not provided a photocopy of records, but instead a new record of her treatment was printed off data stored within the machine's computer.

14. It was also not established that respondent made dishonest or false statements regarding treatment of patient S.S. on March 22, 1999. Complainant relies primarily upon patient S.S.'s recollection of being treated only on March 19, 1999, and the normal four to six week interval between treatments. Records for March 19 show that patient S.S. was treated only on the front of her legs. The records include an illustration of where treatment

was administered on a 1 ½" x 2" figurine. The left and right thighs and shanks are pictured and referenced on March 19, while the back of the left and right thighs and calves are pictured and referenced in the March 22 records. Others, including Vina Basile, were burned on March 22 and this appears to be the only date that patients were burned during treatment. Phone calls were initiated by the office to patients treated on March 22, 1999, including to patient S.S. She was contacted by VCEC employee Ronnie who noted in her patient records that he contacted her on March 25, 1999, and that she had been "burned blistered in all areas treated." Patient S.S. has only complained of injury to the back of her legs, consistent with her being treated on March 22, 1999.

By reason of the above, it was not established that respondent engaged in dishonesty, that he made false entries into the medical records for patient S.S. or that he otherwise engaged in general unprofessional conduct.

Inadequate and/or Inaccurate Medical Records

15. Complainant alleges that respondent failed to maintain custody and control of patient medical records, that respondent failed to create adequate medical records of patients being medically evaluated and given vein treatments, that respondent's handwritten medical record entries for March 19, 1999, were inadequate and that his March 22, 1999 medical records were false.

It was not established that respondent failed to maintain custody and control of patient medical records. Respondent testified that he retained control and custody of all patient medical records and that he was unaware of medical records ever being disseminated to unauthorized persons. When the VCEC Carmel office closed, patient medical records were moved to Modesto. They were not housed with Vina Basile nor did they become part of VCEC's corporate records. There was no evidence to the contrary. There was also no evidence that he failed to create adequate medical records of patients being medically evaluated and treated for vein treatments.

Respondent's handwritten medical record entries for March 19, 1999, were discussed in Finding 13 with regard to dishonesty/false statement allegations. Complainant also contends that the standard of practice for medical recordkeeping requires that any subsequent entries be dated and at least initialed if not signed. Complainant is not satisfied that handwritten entries made within the confines of a computer generated response field are appropriate because a subsequent treating clinician would not absolutely correlate the handwritten notation with the computer generated date. Complainant called as its only medical expert witness John Stuart Nelson, M.D., Ph.D. He is a professor within the Departments of Surgery, Dermatology and Biomedical Engineering at the University of California, Irvine. He is also the Associate Medical Director of the Beckman Laser Institute and Medical Clinic. Dr. Nelson notes that the standard of care requires physicians to document within medical records what the IPL and laser treatment parameters were, the date and time of treatment, and to sign it. If subsequent notations are made, the physician needs to put the date and time on the record where the notations are made, and then initial the

comments to show who was responsible for making the modifications. Dating and signing are required in every case. Dr. Nelson was shown respondent's March 19, 1999 handwritten entries. Because he does not know who wrote it, he cannot say whether it falls within the standard of care. Respondent characterizes his entries as being contemporaneous with the March 19, 1999 treatment, not subsequent notations, and purposely placed within the March 19 computer-generated response field.

It was not established that respondent made the questioned entries subsequent to the March 19, 1999 treatment. Had this been the case a handwritten date and author's initials/signature would have been required. Dr. Nelson was unable to comment on whether the entry fell below the standard of care. For these reasons it was not established that respondent failed to make/maintain proper medical records with regard to the March 19, 1999 handwritten entry. Additional allegations regarding the falsity of the March 22, 1999 medical records were previously addressed above in Finding 14.

Aiding and Abetting the Unlicensed Practice of Medicine

16. This is a question of law, with further discussion reserved for Legal Conclusions. Prior to February 2001, respondent did not know or believe that only licensed individuals could use the PhotoDerm Vasculight machine. He relied largely upon information received from the machine's manufacturer, ESC Medical Systems. Mitchel Paul Goldman, M.D., testified as an expert witness on behalf of respondent. Dr. Goldman is board certified in dermatology and cosmetic surgery. He is an Associate Clinical Professor in Medicine/Dermatology at the University of California, San Diego Medical Center. Dr. Goldman did much of the development and investigation work on IPL and he started ESC Medical Systems, now called Lumenis. He is licensed to practice medicine in six states, including California.

Dr. Goldman notes that there was confusion in California in the late 1990s over whether unlicensed individuals could operate the machines. California was unique in that other states allowed unlicensed individuals to administer IPL. In Dr. Goldman's own practice and other medical practices in California of which he was aware, medical assistants were administering IPL and similar treatments such as electrolysis. Dr. Goldman asked the Board for guidance on this issue and he received a response sometime in 2000 indicating that the Board viewed IPL as a laser device. He believes that there was no clear guidance on this issue until around the time that respondent changed his practice in early 2001.[2]

Cost Recovery.

[2] Complainant made a motion, post hearing, that official notice be taken of the Board's January 1998 Action Report which sets forth the Board's view that only licensed personnel may use lasers and that this does not include medical assistants. This motion was denied as untimely. There was no evidence at hearing that respondent was made aware of the information contained in this Action Report over the relevant period that he allowed Vina Basile to administer IPL/laser treatments.

17. The Board has incurred $4,410.82 as its investigation costs. This is for the four-year period 2000 – 2003. An additional $1,425 was incurred for review/hearing preparation and $40.35 for transcribing.[3] The Board's total request is $5,876 as reasonable costs in connection with its investigation and prosecution of this matter. No costs for attorney fees incurred by the Board were included in the record.

LEGAL CONCLUSIONS

Unlicensed Medical Practice

1. Respondent is charged with aiding and/or abetting the unlicensed practice of medicine. The primary issue is whether unlicensed individuals can administer IPL or laser treatments to patients.

The scope of medical practice is defined by statute. It cannot be expanded by consideration of practitioners' knowledge, skill, experience or what is taught to practitioners in schools and colleges. (See *People v. Mangiagli* (1950) 97 Cal.App.2d Supp. 935, 939; *Crees v. California State Board of Medical Examiners* (1963) 213 Cal.App.2d 195, 204; *Magit v. Board of Medical Examiners* (1961) 57 Cal.2d 74, 85.) Neither can the scope of medical practice be determined by the practices which have developed in the medical profession and are allegedly common. (*Crees v. California State Board of Medical Examiners*, *supra*, 213 Cal.App.2d at pp. 207-208; *Magit v. Board of Medical Examiners*, *supra*, 57 Cal.2d at pp. 85-86.) The custom and practice of a particular industry or profession is not controlling in determining the intent of the legislature. (*Jacobsen v. Board of Chiropractic Examiners* (1959) 169 Cal.App.2d 389, 395; *Bendix Forest Products Corp. v. Division of Occupational Safety and Health* (1979) 25 Cal.3d 465, 471.) Thus, statutory interpretation is purely a question of law.

The fundamental rule of statutory construction is that a court should ascertain the intent of the legislature so as to effectuate the purpose of the law. (*T.M. Cobb Co. v. Superior Court* (1984) 36 cal.3d 273, 277.) Reference is first made to the words of the statute. They are to be construed in context of the nature and obvious purpose of the statute where they appear. An attempt is to be made to give effect to the usual and ordinary import of the language and to avoid making any language mere surplusage. (*Palos Verdes Faculty Assn. v. Palos Verdes Peninsula Unified School District* (1978) 21 Cal.3d 650, 658-659.) Ordinarily, if the statutory language is clear and unambiguous, there is no need for judicial construction. (*California School Employees Assn. v. Governing Board* (1994) 8 Cal.4th 333, 340.)

2. The relevant statute in this case is Business and Professions Code section 2052, subdivision (a), which provides as follows:

[3] Complainant withdrew requests for $2535.04 in expert costs at the time of hearing.

> ...[A]ny person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of doing a valid, unrevoked, or unsuspended certificate as provided in this chapter or without being authorized to perform the act pursuant to a certificate obtained in accordance with some other provision of law is guilty of a public offense, ...

Companion section 2051 of the Business and Professions Code authorizes a physician certificate holder "to use drugs or devices in or upon human beings and to sever or penetrate the tissues of human beings and to use any and all other methods in the treatment of diseases, injuries, deformities, and other physical and mental conditions."

It is clear that the legislature intended to allow only those holding certain certificates to treat blemishes, or other physical conditions. (Bus. & Prof. Code, § 2052, subd. (a).) It is also clear that included within the scope of medical practice is the physician's authority "to penetrate the tissues of human beings and to use any and all other methods" in the treatment of physical conditions. (Bus. & Prof. Code, § 2051.) IPL and laser treatment fall within the ambit of these statutes. These medical devices are designed to treat blemishes or physical conditions involving the veins and skin. Human tissue is penetrated anywhere from 1 to 6 mm depending upon the machine setting. And such tissue penetration is not without attendant risks. The informed consent form warned the patient of the possibility of rare side effects such as scarring and permanent discoloration, as well as short term effects such as reddening, mild burning, temporary unsightly bruising, and temporary discoloration of skin. These negative outcomes were confirmed by medical expert John Stuart Nelson, M.D., and also by the experience of patient S.S. In short, the use of IPL and laser clearly involves penetration of human tissue and therefore falls within the scope of medical practice.

3. Respondent agrees that Business and Professions Code section 2052 is the governing statute. He contends rather that medical "practice" is a term of art and that unlicensed medical assistants are permitted to provide adjunctive and technical supportive services to physicians under authority of Business and Professions Code section 2069. Subdivision (a)(1) of Business and Professions Code section 2069 provides: "Notwithstanding any other provision of law, a medical assistant may administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical supportive services upon the specific authorization and supervision of a licensed physician and surgeon or a licensed podiatrist." "Specific authorization" means a specific written order prepared by the supervising physician authorizing the procedures to be performed and placed in the patient's medical record. (Bus. & Prof. Code, § 2069, subd. (b)(2).) "Supervision" must be by one "who shall be physically present in the treatment facility during the performance of those procedures." (Bus. & Prof. Code, § 2069, subd. (b)(3).) "Technical supportive services" is defined as "simple routine medical tasks and

procedures that may be safely performed by a medical assistant who has limited training and who functions under the supervision of a license physician and surgeon...." (Bus. & Prof. Code, § 2069, subd. (b)(4).) Regulations set forth specific technical supportive services that can be performed by medical assistants, including administration of medications orally, sublingually, topically, vaginally or rectally; performing electrocardiogram, electroencephalogram or plethysmography tests; application and removal of bandages and dressings and certain orthopedic appliances; removal of sutures or staples from superficial incisions or lacerations, performing ear lavage; and collection by non-invasive techniques specimens for testing. (Cal. Code Regs., tit. 16, § 1366, subd. (b).)

Respondent notes that medical assistants are allowed by law to perform procedures at least as invasive as IPL or laser treatments, including administration of medication by intramuscular injections. He contends that medical assistants who are merely providing adjunctive services to a physician's medical practice and who are not practicing a particular profession – that is to say, they are not independently exercising discretion and specialized training to prescribe and implement a course of action – are not practicing medicine. (*PM & R Associates v. Workers Comp. Appeals Bd.* (2000) 80 Cal.App.4th 357.) Respondent believes Vina Basile's administration of IPL and laser treatment should be viewed in this same light.

4. Business and Professions Code section 2069 carefully limits the type of, and manner by which medical assistants perform certain procedures. In all cases the procedures must be performed while certain approved supervisors are physically present in the treatment facility. Respondent was not always physically present when Vina Basile administered IPL and laser treatments to patients. The tasks performed by medical assistants are to be "simple routine medical tasks and medical procedures" that may be performed by one who has limited training. In some respects, Vina Basile performed in a strictly adjunctive capacity to respondent. Respondent, and not Vina Basile, was responsible for making overall treatment decisions. For example, it was respondent who obtained patient histories, performed physical examinations, determined whether patients were appropriate candidates for treatment and who determined appropriate machine settings. Vina Basile exercised no independent discretion and she had not authority in these areas. Yet it was Vina Basile who was 100 percent shareholder and sole corporate officer for VCEC. It was her business. Importantly, the treatment was not ancillary to respondent's workup or diagnosis of a patient's condition. Instead, it was the primary treatment mode sought by patients seeking removal of unsightly varicose veins or other cosmetic blemishes. In that regard it differs from most, if not all, of the "technical supportive services" routinely performed by medical assistants. (Cal. Code Regs., tit. 16, § 1366, subd. (b).) When Vina Basile provided IPL/laser treatment to patients, particularly when respondent was absent from the facility, she was not performing adjunctive services for respondent. She engaged in the unlicensed practice of medicine.

Respondent points out that intradermal, subcutaneous or intramuscular injections performed by medical assistants involve more penetration of human tissue than IPL or laser. However, these are limited exceptions, set forth in statute, to the general rule limiting those

who are authorized to penetrate tissue for medical purposes. And even before medical assistants can perform intramuscular, subcutaneous and intradermal injections, or venipuncture for the purposes of withdrawing blood, they are required to complete minimum training (10 hours for each of the different procedures) and to demonstrate proficiency to their supervising physicians. (Cal. Code Regs., tit. 16, § 1366.1.) No such regulations are in place to ensure that medical assistants operating IPL/laser machines are adequately trained. The training received by Vina Basile from ESC Medical Systems may have been adequate, but it is irrelevant to the question of whether there is a legislative intent to include procedures such as IPL/laser within the definition of "technical supportive services" that can be performed by medical assistants. That simply does not appear to be the case at this time. Absent further legislative authority and/or regulatory action, medical assistants cannot legally perform IPL/laser treatments on patients.

5. Respondent aided and/or abetted the unlicensed practice of medicine by allowing Vina Basile to use the IPL/laser to treat patients. Business and Professions Code section 2264 provides: "The employing, directly or indirectly, the aiding, or the abetting of any unlicensed person ... to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct." A violation of section 2264 does not require a showing of either knowledge or intent on the part of the practitioner. (*Khan v. Medical Board* (1993) 12 Cal.App.4th 1834, 1844-1845.) The objective of section 2264 is the protection of the public from certain forms of treatment by unlicensed and presumably unqualified persons. (*Newhouse v. Board of Osteopathic Examiners* (1958) 159 Cal.App.2d 728, 734.)

For these reasons, cause for disciplinary actions exists under Business and Professions Code section 2264. Respondent engaged in unprofessional conduct by aiding and/or abetting the unlicensed practice of medicine by Vina Basile.

6. Advertising Without Use of Name or Fictitious Name Permit. Cause for disciplinary action exists under Business and Professions Code sections 2272 and/or 2285, by reason of the matters set forth in Finding 7. Respondent engaged in advertising without the use of his own name and/or without a fictitious name permit issued by the Board.

7. Dishonesty/Making False Statements/General Unprofessional Conduct. No cause for disciplinary action exists under Business and Professions Code sections 2234, 2261 and 2234, subdivision (e), by reason of the matters set forth in Findings 12 through 14.

8. Inadequate and/or Inaccurate Medical Records. No cause for disciplinary action exists under Business and Professions Code section 2266, by reason of the matters set forth in Finding 15.

9. Under Business and Professions Code section 125.3, the Board may request the administrative law judge to direct any licentiate found to have committed a violation of the licensing act to pay the Board a sum not to exceed the reasonable costs of investigation and enforcement of the case. The Board has incurred costs of $5,876 in connection with its

investigation and enforcement of this case. The Board must not assess the full costs of investigation and prosecution when to do so will unfairly penalize a licensee who has committed some misconduct, but who has used the hearing process to obtain dismissal of other charges or a reduction in the severity of the discipline imposed. The Board must consider the licensee's "subjective good faith belief in the merits of his or her position" and whether the licensee has raised a "colorable challenge" to the proposed discipline. (*Zuckerman* v. *Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, 45.) Such factors have been considered in this matter. Respondent has successfully defended against allegations based on dishonesty, making false statements, general unprofessional conduct and inadequate and/or inaccurate medical records. The focus of this case was largely on allegations relating to his aiding and abetting the unlicensed practice of medicine, an issue to which he raised a colorable challenge. An adjustment of costs to $4,000 would fairly and equitably account for these several factors. Documentation of attorney costs was not submitted.

10. Board disciplinary guidelines for aiding and abetting the unlicensed practice of medicine call for a minimum penalty of stayed revocation and five years probation. At the time that the offense occurred, Board disciplinary guidelines called for a minimum penalty of stayed revocation and three years probation for this offense. The matters set forth in Findings 11 and 16 were considered. There may have been some confusion over whether Vina Basile could lawfully provide IPL/laser treatments to patients, but by November 2000, respondent was made aware of continued concerns over this practice by the Monterey County Medical Society, and he should have sought definitive guidance from the Board at that time. When he did determine that only licensed personnel should operate the machine, he deferred hiring a registered nurse until after he moved to Modesto. He allowed Vina Basile to perform IPL/laser treatment at a time when he understood her authority to do so was, at best, uncertain. He also allowed her to provide such treatment when he was absent from the facility. Disciplinary action is appropriate under these circumstances. Protection of the public does not require more than the minimum penalty of stayed revocation and three years probation. Respondent's violation of Business and Professions Code section 2285 (Fictitious Name Violation) is viewed as a technical violation.

ORDER

Physician's and Surgeon's Certificate No. G-74601 issued to respondent Joseph F. Basile, M.D. is revoked pursuant to Legal Conclusions 5 and 6, jointly; and Legal Conclusion 5 individually. However, revocation is stayed and respondent is placed on probation for three (3) years upon the following terms and conditions:

1. Notification. Prior to engaging in the practice of medicine Respondent shall provide a true copy of the Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum

tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days. This condition shall apply to any change in hospitals, other facilities or insurance carrier.

2. Supervision of Physician Assistants. During probation, respondent is prohibited from supervising physician assistants.

3. Obey All Laws. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

4. Quarterly Declarations. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

5. Probation Unit Compliance. Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b). Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

   Respondent shall immediately inform the Division or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

6. Interview with the Division or Its Designee. Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Division or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

7. Residing or Practicing Out-of-State. In the event respondent should leave the State of California to reside or to practice respondent shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California totals two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

8. Failure to Practice Medicine - California Resident. In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not

engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

9. Violation of Probation. Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

10. Cost Recovery. Within 90 calendar days from the effective date of the Decision or other period agreed to by the Division or its designee, respondent shall reimburse the Division the amount of $4,000 for its investigative and prosecution costs. The filing of bankruptcy or period of non-practice by respondent shall not relieve respondent his obligation to reimburse the Division for its costs.

11. License Surrender. Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Division or its designee and

respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action.

If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

12. Probation Monitoring Costs. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

13. Completion of Probation. Respondent shall comply with all financial obligations (e.g., cost recovery, restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon completion successful of probation, respondent's certificate shall be fully restored.

DATED: July 16, 2004

JONATHAN LEW
Administrative Law Judge
Office of Administrative Hearings

EXHIBIT 3

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: JOSEPH F. BASILE, M.D. 130 Coffee Road, Suite 7 Modesto, California 95355 Physician and Surgeon's Certificate No. G 74601 Respondent.	Case No. 03-2000-108170 OAH No. N2002050521

PROPOSED DECISION

This matter was heard before Administrative Law Judge Jonathan Lew, State of California, Office of Administrative Hearings on May 24 through 27, and June 16, 2004, in Oakland, California.

Jose R. Guerrero, Deputy Attorney General, represented complainant.

Robert B. Zaro, Esq., represented Joseph F. Basile, M.D., who was present.

The case was submitted for decision on June 16, 2004.

FACTUAL FINDINGS

1. Complainant Ronald Joseph was formerly the Executive Director of the Medical Board of California (Board). The Accusation and First and Second Amended Accusations were issued by him in his official capacity.

2. On July 9, 1992, the Board issued Joseph F. Basile, M.D. (respondent) Physician and Surgeon's Certificate No. G 74601. The certificate was current at all times pertinent to this matter. It was due to expire on May 31, 2004, if not renewed. There has been no prior disciplinary action taken against this certificate.

3. The allegations against respondent arise from his involvement in and operation of a medical office called "The Vein & Cosmetic Enhancement Center" (VCEC).

* * * * * * *

4. Professional Background. Respondent attended Georgetown University School of Medicine, graduating in 1987. He completed a portion of his residency at Georgetown University before transferring to St. Francis Hospital, affiliated with the University of Connecticut. Respondent became board certified in general surgery in April 1996. Between 1992 and 1999 he was on the medical staff of Salinas Surgery Center in Salinas, California. He also associated with the Monterey Peninsula Surgery Center. He describes his work in Salinas as a "bread and butter general surgery practice" involving hernia repairs, gall bladder, blunt trauma, cancers of all sorts and gastrointestinal surgery. Respondent also served as the medical director of VCEC, a business wholly owned by his wife, Vina Basile. She is neither a physician nor a nurse and she holds no other health profession licenses. VCEC was located in Carmel. Respondent relocated his medical practice to Modesto, where he worked for a short time with the Stanislaus County Health Services Agency. Vina Basile remained behind and continued to work in the Carmel VCEC office for a period before that office was closed in March 2001. VCEC moved to Modesto and respondent continued there in his position as its medical director.

5. PhotoDerm Vasculight Machine. Much of this case revolves around the use of a medical device known as a PhotoDerm Vasculight machine. In 1998, respondent became interested in new equipment that could be used for certain cosmetic procedures in a medical office setting. He leased a PhotoDerm Vasculight machine from a company called ESC Medical Systems, and this machine was delivered to his Salinas office in September or October 1998. The PhotoDerm Vasculight machine was designed for the treatment/removal of pigmented lesions, varicose veins, spider veins, reticular veins, age spots and hair. It works on the principle of light selectively being absorbed into pigment and then being converted into heat energy. The heat induces photocoagulation of blood vessels, a mild thermal destruction, without actually bursting the vessels. The body apparently repairs this damage and absorbs the damaged vein. This process causes the vein or cosmetic blemishes to fade. The concept and technology were developed and tested through the early 1990s, and approved by the Food and Drug Administration in early 1994. It is viewed as a relatively safe and non-invasive alternative to previous modes of removing blemishes. For example, one alternative, sclerotherapy, requires injection of an irritating solution to destroy the inner lining of veins, causing clotting and spasm. The new technology eliminated the need for sclerotherapy for most patients.

There are other light emitting devices on the market similar to the one manufactured by ESC Medical Systems. However, the PhotoDerm Vasculight machine is unique in that it combines two light components into a single unit. The PhotoDerm component emits intense pulse light (IPL) through a hand piece, 5 to 15 mm wide. Filters are used to vary the wavelength of light emitted and this will affect the degree of skin penetration. For example, shorter wavelengths (550 nanometers (nm)) will penetrate 1 – 2 mm, and longer wavelengths (near the infrared spectrum) will penetrate 4 – 6 mm. The amount or dose of light delivered per surface unit area is called fluence, and it is measured in joules per square centimeter (J/cm^2). The duration and number of pulses can also be varied. The operator may input these several parameters into a computer software program that allows for individualized settings. Patients are typically categorized according to a Fitzpatrick skin type scale that

incorporates their responses to a questionnaire on genetic disposition, reaction to sun exposure and tanning habits. The resulting Fitzpatrick scaled score (Skin Types I – VI) will guide the operator in making appropriate settings. The PhotoDerm or IPL component is particularly effective for treating the small varicose and "spider veins."

The second component (Vasculight) is essentially a laser. It is a single very long wavelength (1064 nm) of light amplified by reflecting mirrors. The beam from the laser hand piece is relatively small (4 mm circle) and because it emits a stronger and more coherent light beam it can be used effectively to treat larger veins. The Photoderm Vasculight machine operator can alternate between IPL or laser settings. The machine itself can also provide the operator with recommended settings based on the patient's skin type and the type of lesion (small, medium or deep) that is being treated. The operator may accept these settings or enter different ones. When the treatment is completed, information about each patient's treatment is stored in the machine's computer and can be retrieved later and printed at any time. These records contain patient identifying information, skin type, date and site of treatment, and the settings/figures for wavelength, fluence, pulse duration and number. The operator can also type narrative information under sections describing "Immediate response" and "Note."

6. Respondent and Vina Basile both received training on the operation and use of the PhotoDerm Vasculight from the manufacturer. Both operated the machine. Vina Basile was VCEC's only officer and sole shareholder. Respondent was a non-salaried employee of VCEC. His duties as the corporation's medical director were to obtain patient histories, conduct physical examinations and determine whether individuals were viable candidates for cosmetic procedures. After obtaining the patient's Fitzpatrick skin typing he would determine the appropriate IPL or laser settings for patients. Respondent also had sole responsibility for preparing and submitting patient medical evaluations and for setting fees. There were times when Vina Basile used the machine on patients without respondent also being present.

* * * * * * *

LEGAL CONCLUSIONS

Unlicensed Medical Practice

1. Respondent is charged with aiding and/or abetting the unlicensed practice of medicine. The primary issue is whether unlicensed individuals can administer IPL or laser treatments to patients.

The scope of medical practice is defined by statute. It cannot be expanded by consideration of practitioners' knowledge, skill, experience or what is taught to practitioners in schools and colleges. (See *People v. Mangiagli* (1950) 97 Cal.App.2d Supp. 935, 939; *Crees v. California State Board of Medical Examiners* (1963) 213 Cal.App.2d 195, 204;

Magit v. Board of Medical Examiners (1961) 57 Cal.2d 74, 85.) Neither can the scope of medical practice be determined by the practices which have developed in the medical profession and are allegedly common. (*Crees v. California State Board of Medical Examiners*, *supra*, 213 Cal.App.2d at pp. 207-208; *Magit v. Board of Medical Examiners*, *supra*, 57 Cal.2d at pp. 85-86.) The custom and practice of a particular industry or profession is not controlling in determining the intent of the legislature. (*Jacobsen v. Board of Chiropractic Examiners* (1959) 169 Cal.App.2d 389, 395; *Bendix Forest Products Corp. v. Division of Occupational Safety and Health* (1979) 25 Cal.3d 465, 471.) Thus, statutory interpretation is purely a question of law.

The fundamental rule of statutory construction is that a court should ascertain the intent of the legislature so as to effectuate the purpose of the law. (*T.M. Cobb Co. v. Superior Court* (1984) 36 cal.3d 273, 277.) Reference is first made to the words of the statute. They are to be construed in context of the nature and obvious purpose of the statute where they appear. An attempt is to be made to give effect to the usual and ordinary import of the language and to avoid making any language mere surplusage. (*Palos Verdes Faculty Assn. v. Palos Verdes Peninsula Unified School District* (1978) 21 Cal.3d 650, 658-659.) Ordinarily, if the statutory language is clear and unambiguous, there is no need for judicial construction. (*California School Employees Assn. v. Governing Board* (1994) 8 Cal.4th 333, 340.)

2. The relevant statute in this case is Business and Professions Code section 2052, subdivision (a), which provides as follows:

> ...[A]ny person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of doing a valid, unrevoked, or unsuspended certificate as provided in this chapter or without being authorized to perform the act pursuant to a certificate obtained in accordance with some other provision of law is guilty of a public offense, ...

Companion section 2051 of the Business and Professions Code authorizes a physician certificate holder "to use drugs or devices in or upon human beings and to sever or penetrate the tissues of human beings and to use any and all other methods in the treatment of diseases, injuries, deformities, and other physical and mental conditions."

It is clear that the legislature intended to allow only those holding certain certificates to treat blemishes, or other physical conditions. (Bus. & Prof. Code, § 2052, subd. (a).) It is also clear that included within the scope of medical practice is the physician's authority "to penetrate the tissues of human beings and to use any and all other methods" in the treatment of physical conditions. (Bus. & Prof. Code, § 2051.) IPL and laser treatment fall within the

ambit of these statutes. These medical devices are designed to treat blemishes or physical conditions involving the veins and skin. Human tissue is penetrated anywhere from 1 to 6 mm depending upon the machine setting. And such tissue penetration is not without attendant risks. The informed consent form warned the patient of the possibility of rare side effects such as scarring and permanent discoloration, as well as short term effects such as reddening, mild burning, temporary unsightly bruising, and temporary discoloration of skin. These negative outcomes were confirmed by medical expert John Stuart Nelson, M.D., and also by the experience of patient S.S. In short, the use of IPL and laser clearly involves penetration of human tissue and therefore falls within the scope of medical practice.

3. Respondent agrees that Business and Professions Code section 2052 is the governing statute. He contends rather that medical "practice" is a term of art and that unlicensed medical assistants are permitted to provide adjunctive and technical supportive services to physicians under authority of Business and Professions Code section 2069. Subdivision (a)(1) of Business and Professions Code section 2069 provides: "Notwithstanding any other provision of law, a medical assistant may administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical supportive services upon the specific authorization and supervision of a licensed physician and surgeon or a licensed podiatrist." "Specific authorization" means a specific written order prepared by the supervising physician authorizing the procedures to be performed and placed in the patient's medical record. (Bus. & Prof. Code, § 2069, subd. (b)(2).) "Supervision" must be by one "who shall be physically present in the treatment facility during the performance of those procedures." (Bus. & Prof. Code, § 2069, subd. (b)(3).) "Technical supportive services" is defined as "simple routine medical tasks and procedures that may be safely performed by a medical assistant who has limited training and who functions under the supervision of a license physician and surgeon...." (Bus. & Prof. Code, § 2069, subd. (b)(4).) Regulations set forth specific technical supportive services that can be performed by medical assistants, including administration of medications orally, sublingually, topically, vaginally or rectally; performing electrocardiogram, electroencephalogram or plethysmography tests; application and removal of bandages and dressings and certain orthopedic appliances; removal of sutures or staples from superficial incisions or lacerations, performing ear lavage; and collection by non-invasive techniques specimens for testing. (Cal. Code Regs., tit. 16, § 1366, subd. (b).)

Respondent notes that medical assistants are allowed by law to perform procedures at least as invasive as IPL or laser treatments, including administration of medication by intramuscular injections. He contends that medical assistants who are merely providing adjunctive services to a physician's medical practice and who are not practicing a particular profession – that is to say, they are not independently exercising discretion and specialized training to prescribe and implement a course of action – are not practicing medicine. (*PM & R Associates v. Workers Comp. Appeals Bd.* (2000) 80 Cal.App.4th 357.) Respondent believes Vina Basile's administration of IPL and laser treatment should be viewed in this same light.

4. Business and Professions Code section 2069 carefully limits the type of, and manner by which medical assistants perform certain procedures. In all cases the procedures must be performed while certain approved supervisors are physically present in the treatment facility. Respondent was not always physically present when Vina Basile administered IPL and laser treatments to patients. The tasks performed by medical assistants are to be "simple routine medical tasks and medical procedures" that may be performed by one who has limited training. In some respects, Vina Basile performed in a strictly adjunctive capacity to respondent. Respondent, and not Vina Basile, was responsible for making overall treatment decisions. For example, it was respondent who obtained patient histories, performed physical examinations, determined whether patients were appropriate candidates for treatment and who determined appropriate machine settings. Vina Basile exercised no independent discretion and she had not authority in these areas. Yet it was Vina Basile who was 100 percent shareholder and sole corporate officer for VCEC. It was her business. Importantly, the treatment was not ancillary to respondent's workup or diagnosis of a patient's condition. Instead, it was the primary treatment mode sought by patients seeking removal of unsightly varicose veins or other cosmetic blemishes. In that regard it differs from most, if not all, of the "technical supportive services" routinely performed by medical assistants. (Cal. Code Regs., tit. 16, § 1366, subd. (b).) When Vina Basile provided IPL/laser treatment to patients, particularly when respondent was absent from the facility, she was not performing adjunctive services for respondent. She engaged in the unlicensed practice of medicine.

Respondent points out that intradermal, subcutaneous or intramuscular injections performed by medical assistants involve more penetration of human tissue than IPL or laser. However, these are limited exceptions, set forth in statute, to the general rule limiting those who are authorized to penetrate tissue for medical purposes. And even before medical assistants can perform intramuscular, subcutaneous and intradermal injections, or venipuncture for the purposes of withdrawing blood, they are required to complete minimum training (10 hours for each of the different procedures) and to demonstrate proficiency to their supervising physicians. (Cal. Code Regs., tit. 16, § 1366.1.) No such regulations are in place to ensure that medical assistants operating IPL/laser machines are adequately trained. The training received by Vina Basile from ESC Medical Systems may have been adequate, but it is irrelevant to the question of whether there is a legislative intent to include procedures such as IPL/laser within the definition of "technical supportive services" that can be performed by medical assistants. That simply does not appear to be the case at this time. Absent further legislative authority and/or regulatory action, medical assistants cannot legally perform IPL/laser treatments on patients.

5. Respondent aided and/or abetted the unlicensed practice of medicine by allowing Vina Basile to use the IPL/laser to treat patients. Business and Professions Code section 2264 provides: "The employing, directly or indirectly, the aiding, or the abetting of any unlicensed person ... to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct." A violation of section 2264 does not require a showing of either knowledge or intent on the part of the practitioner. (*Khan v. Medical Board* (1993) 12 Cal.App.4th 1834, 1844-1845.) The

objective of section 2264 is the protection of the public from certain forms of treatment by unlicensed and presumably unqualified persons. (*Newhouse v. Board of Osteopathic Examiners* (1958) 159 Cal.App.2d 728, 734.)

For these reasons, cause for disciplinary actions exists under Business and Professions Code section 2264. Respondent engaged in unprofessional conduct by aiding and/or abetting the unlicensed practice of medicine by Vina Basile.

* * * * * * *

DATED: July 16, 2004

JONATHAN LEW
Administrative Law Judge
Office of Administrative Hearings

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
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Agenda Item 9-B

MEMORANDUM

DATE June 26, 2007

TO Members
Division of Medical Quality
Medical Board of California

FROM Anita Scuri
Supervising Senior Counsel
Department of Consumer Affairs

SUBJECT **PROPOSED PRECEDENTIAL DECISION**
In the Matter of the Accusation Against Tod H. Mikuriya, M.D.
Case No. 12-1999-98783
OAH No. N2002110020

In accordance with 16 Cal.Code Regs. section 1364.40 and with the procedure adopted by the Division of Medical Quality ("Division") in July 2004, the Office of the Attorney General has recommended that the above-captioned decision be designated as Precedential. The executive director, chief of enforcement and I all agree with this recommendation.

Procedural Background

Dr. Mikuriya ("respondent") was the subject of an Accusation (and several amendments thereto) that was heard before Administrative Law Judge Jonathan Lew, who submitted a Proposed Decision to the Division on January 30, 2004. The Division adopted that decision and respondent petitioned for a writ of mandate. The court granted that writ as to one issue and denied it as to all other issues. The Division then modified its decision in the manner directed by the court and reaffirmed its conclusion that the penalty initially imposed was still appropriate.

Facts/Findings of the Case

The Accusation charged respondent with a variety of violations, stemming from his care and treatment of sixteen patients. In each case, respondent had recommended marijuana for medical purposes.

This decision primarily addresses two important legal issues:

1. What is the standard of care applicable to a physician who is recommending marijuana for medical use?

2. Does the Compassionate Use Act of 1996 (Health and Safety Code Section 11362.5) immunize a physician from disciplinary action even in those cases where the physician's care falls below the accepted standard?

The decision analyzes the issues and thoughtfully articulates answers to these two questions, which answers I have summarized below as follows:

1. The standard of care for conducting a medical marijuana evaluation is identical to that followed by physicians in recommending any other treatment or medication and it applies regardless of whether the physician is acting as a treating or as a consulting physician.

2. The Compassionate Use Act is conditional and does not immunize a physician from disciplinary action in those cases where the physician's care falls below the accepted standard.

Rationale

16 Cal. Code Regs. 1364.40(a) authorizes the Division to designate, as a precedent decision, "any decision or part of any decision that contains a significant legal or policy determination of general application that is likely to recur."

The analysis and legal conclusions set forth in the decision conform to the policy statement adopted by the board on May 7, 2004 regarding the standard of practice for conducting medical marijuana evaluations. The pertinent provision of that statement is:

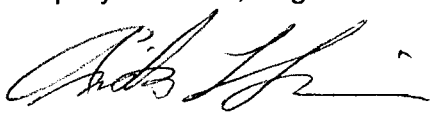
"In other words, if physicians use the same care in recommending medical marijuana to patients as they would recommending or approving any other medication, they have nothing to fear from the Medical Board."

The issues of standard of care and immunity have broad application to physician practices and are likely to recur in future matters involving recommendations for medical marijuana.

Designation of this case as precedent would incorporate the essence of the policy directive quoted above and would provide binding guidance to physicians, their advisors, law enforcement agencies, and the general public on the appropriate standard of care for conducting medical marijuana evaluations and would inform them that the Compassionate Use Act is conditional and does not immunize a physician from

disciplinary action in those cases where the physician's care falls below the accepted standard.

DOREATHEA JOHNSON
Deputy Director, Legal Affairs



ANITA L. SCURI
Supervising Sr. Counsel

Attachments

cc: Kurt Heppler
Jane Zack Simon
Lawrence A. Mercer

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: TOD H. MIKURIYA, M.D. 1168 Sterling Avenue Berkeley, California 94708 Physician's and Surgeon's Certificate No. G-9124 Respondent.	Case No. 12-1999-98783 OAH No. N2002110020

DECISION AFTER REMAND FROM SUPERIOR COURT

This matter was heard before Administrative Law Judge Jonathan Lew, State of California, Office of Administrative Hearings on September 3, 4, 5, 8, 9 and 24, 2003, in Oakland, California.

Complainant Ron Joseph was represented by Deputy Attorneys General Lawrence A. Mercer and Jane Zack Simon.

Respondent Tod H. Mikuriya, M.D. was present and represented by John L. Fleer, Esq., Susan J. Lea, Esq. and William M Simpich, Esq.

Submission of the matter was deferred pending receipt of closing argument. Complainant's Closing Argument and Reply Brief were received on November 7 and 20, 2003, and marked respectively as Exhibits 26 and 27 for identification. Respondent's Closing Brief and Reply Brief were received on November 7 and 21, 2003, and marked respectively as Exhibits AA and BB for identification. The case was submitted for decision on November 21, 2003[1]

[1] On December 26, 2003, respondent also submitted an Amicus Curiae Brief filed by the California Medical Association in a matter before the California Court of Appeal that respondent believes directly concerns the facts in this case. Respondent requests that judicial notice be taken of that brief. Complainant filed an Objection to Request for Judicial Notice on December 26, 2003, and such objection is sustained.

On January 30, 2004, the administrative law judge submitted his proposed decision to the Medical Board of California. The board adopted that decision on March 18, 2004, to become effective on April 19, 2004.

Thereafter, respondent filed a Petition for Writ of Mandate in Sacramento County Superior Court, Case No. 04CS00477. On November 2, 2006, the court issued its Order in the matter, granting the peremptory writ of administrative mandamus solely to the extent that the board based its decision on a finding of unprofessional conduct based on a violation of section 2242 and denying the Petition on all other grounds.

The Superior Court of the State of California, pursuant to its Judgment and Order dated November 2, 2006, commanded this board to reconsider its Decision in light of the court's finding.

Having reconsidered its Decision pursuant to the court's direction in the Judgment and Order, the board now makes a modified decision in compliance with the Judgment and Order dated November 2, 2006. A copy of the Judgment and Order is attached as Exhibit "A" and incorporated herein by reference.

FACTUAL FINDINGS

1. Ron Joseph (complainant) is the Executive Director of the Medical Board of California (Board), Department of Consumer Affairs. He brought the Accusation, First and Second Amended Accusations solely in his official capacity.

2. On October 16, 1963, the Board issued Physician's and Surgeon's Certificate Number G-9124 to Tod Hiro Mikuriya, M.D. (respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times pertinent to this case.

3. On July 25, 2003, a Second Amended Accusation was filed against respondent alleging unprofessional conduct, gross negligence, negligence and incompetence arising out of his care and treatment of sixteen patients. In each case he recommended marijuana for medical purposes. Complainant alleges that respondent's medical records for these patients were inadequate in that they routinely lacked adequate documentation of physical examination, clinical findings, vital signs, mental status examination, laboratory tests, follow-up and treatment plans. Complainant contends such matters are relevant and necessary to an evaluation and diagnosis of each patient's condition, or to support the recommendation or prescription of any medication. Complainant further alleges that respondent prescribed, dispensed or furnished marijuana, a controlled substance, without conducting a prior good-faith examination and/or without medical indication. Finally, complainant contends that respondent committed unprofessional conduct and/or was grossly negligent, negligent, incompetent or committed acts of dishonesty or corruption in his interactions with and care and treatment of an undercover narcotics officer.

Respondent's Background

4. Respondent has been a licensed California physician for 40 years. He is recognized as an expert on the use of marijuana for medical purposes and he has conducted research and has numerous publications on the topic of medical marijuana. He founded California Cannabis Research Medical Group to facilitate shared cannabis research. Respondent has been actively involved in the efforts to legalize marijuana for medical purposes.

Respondent attended Temple University School of Medicine before completing psychiatric residencies at Oregon State Hospital in Salem, Oregon, and Mendocino State Hospital in Talmage, California. He has served as Director, Drug Addiction Treatment Center, New Jersey NeuroPsychiatric Institute, Princeton, New Jersey (1966-67); Consulting Research Psychiatrist, National Institute of Mental Health Center for Narcotics and Drug Abuse Studies (1967); Consulting Psychiatrist, Alameda County Alcoholism Clinic, Oakland (1968-69); Consulting Psychiatrist, Alameda County Health Department Drug Abuse Project (1969); Attending Staff Psychiatrist, Gladman Hospital, Oakland (1969-92); Consultant, National Commission on Marihuana and Drug Abuse (1972); Chair, Department of Psychiatry, Eden Hospital, Castro Valley (1993-94); and Psychiatric Consultant, Fairmont Hospital, San Leandro (1991-95).

He is currently an attending psychiatrist at Eden Medical Center, Castro Valley; Vencor Hospital, San Leandro; San Leandro Hospital, San Leandro; and St. Anthony's, Park View Convalescent, Clinton Village. He describes his private practice in Berkeley as all about medicinal cannabis consultations and this includes activities in his role as Medical Coordinator of California Cannabis Centers (Oakland Cannabis Buyers Cooperative, Hayward Hempery, CHAMP, San Francisco and the Humboldt Cannabis Center, Arcata).

Respondent is a member of professional organizations including the California Medical Association, Alameda-Contra Costa Medical Association (Chemical Addictions Committee), American Psychiatric Association, Northern California Psychiatric Society, East Bay Psychiatric Association, American Society of Addiction Medicine and the California Society of Addiction Medicine (CSAM). He has been on CSAM's Medical Marijuana Task Force since April 1997.

The Compassionate Use Act

5. On November 5, 1996, the voters of California passed Proposition 215, the Compassionate Use Act of 1996, also known as the Medical Marijuana Initiative. (Health & Saf. Code, § 11362.5.) The Compassionate Use Act provides that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana. The Act makes specific provision for the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief. One of the Act's purposes

is to ensure that seriously ill Californians have the right to obtain and use marijuana for "medical purposes" and "where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana." (*Ibid.*)

The Act also expressly affirms public policy against conduct that endangers others or the diversion of marijuana for non-medical purposes. It is left for the physician, as gatekeeper, to ensure that marijuana is used for "medical purposes" to benefit the seriously ill[2]. Under these circumstances it is presumed that physicians who recommend marijuana under the Act will follow accepted medical practice standards and make good faith recommendations based on honest medical judgments. (*Conant* v. *McCaffrey* (2000 WL 1281174.) The parties agree that good faith recommendations based on honest medical judgments must be made in every case. Where they differ, and rather markedly so, is on what constitute accepted medical practice standards to be followed in making such a recommendation.

Standard of Practice Issues

6. Complainant sees no need to articulate a new standard of practice to assist physicians in recommending marijuana, believing that the standard of practice in the area of medical marijuana is not new at all, but the same as pertains to recommending any treatment or prescribing any other medication – namely history, physical examination and appropriate treatment plan. Where marijuana is being recommended for a psychiatric condition, complainant believes the examination would entail a mental status examination to establish a psychiatric diagnosis, and might either not include a physical examination or might only include a limited physical examination appropriate to the clinical situation. Complainant relies heavily upon a policy statement issued by the Board to all California physicians in its January 1997 Action Report. This statement came on the heels of Proposition 215 and recognized that there was at that time "a great deal of confusion concerning the role of physicians under this law." The policy statement specifies:

> While the status of marijuana as a Schedule I drug means that no objective standard exists for evaluating the medical rationale for its use, there are certain standards that always apply to a physician's practice that may be applied. In this area, the Board would expect that any physician who recommends the use of marijuana by a patient should have arrived at that decision in accordance with accepted standards of medical responsibility; i.e., history and physical examination of the patient; development of a treatment plan with objectives; provision of informed consent, including discussion of side effects; periodic

[2] In *Conant* v. *Walters* (2002) 309 F.3d 629, Justice Kozinski described the key role of physicians anticipated under the Act: "The state law in question does not legalize use of marijuana by anyone who believes he has a medical need for it. Rather, state law is closely calibrated to exempt from regulation only patients who have consulted a physician. And the physician may only recommend marijuana when he has made an individualized and bona fide determination that the patient is within the small group that may benefit from its use."

review of the treatment's efficacy and, of critical importance especially during this time of uncertainty, proper record keeping that supports the decision to recommend the use of marijuana.

In spring of 1997, CSAM issued a position statement regarding the recommendation of marijuana, in which it stated that marijuana is a mood-altering drug capable of producing dependency, urging the Board to formally adopt the standards set forth in the January 1997 Action Report, and further suggesting that the Board's statement be expanded to include a requirement for notation of a diagnosis or differential diagnosis.

7. Respondent notes that there are only a handful of physicians, less than twenty, who consult on medical cannabis issues as a primary part of their practice and among whom there is no uniform agreement and few guidelines on practice standards. Physicians consulting in this way are not "treating physicians" and patients who are seen are primarily self-referred and come with a single question in mind – "Do I qualify for a medical cannabis recommendation?" These patients typically are already using cannabis for their medical condition and claim a benefit from so doing. In seeking a physician's recommendation their main consideration is avoiding involvement with the criminal justice system. Most physicians are very reluctant to become involved in making such recommendations. They are afraid to say anything to patients about medical cannabis for fear that they will become targets of law enforcement themselves. The Compassionate Use Act does provide that no physician shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes. (Health and Saf. Code, § 11362.5, subd. (c).) However, as even the Board recognized early on, this language offers no protection from federal prosecution, including threat of criminal prosecution of physicians, revocation of DEA registration and exclusion from participation in the Medicare and Medicaid program for having made such recommendations.[3]

Given this history and climate respondent believes this case has been motivated politically, directed both by federal government officials and California State officials opposed to Proposition 215, and conducted from the outset in bad faith. Yet, in considering this case, every effort has been made to remain squarely focused on determining what practice standards govern medical cannabis recommendations. That is the primary issue and therefore evidence proffered on the history, motivation and other matters underlying or relating to the investigation and prosecution of this case, though considered, have been largely disregarded.[4]

8. Respondent urges as the standard of practice a more focused medical cannabis consultation model consisting of a good faith examination designed to gain needed information, no more and no less. The needed information would be limited to that sought in

[3] January 17, 1997 Memorandum to Board Members from Ron Joseph regarding Proposition 215, Use of Marijuana for Medicinal Purposes.

[4] Respondent submitted an Offer of Proof on remaining Exhibits P – W. These exhibits have been received into evidence as marked. Objections to relevancy go largely to the weight attached, and in most cases this was very marginal

answering the simple question whether a patient is eligible for inclusion under the Compassionate Use Act. Respondent believes a physician would primarily be concerned with determining if there is medical evidence supporting eligibility. There would also be a future obligation to monitor patients using medical marijuana. Respondent proposes as minimum practice standards that physicians conduct an initial face to face interview, obtain identifying information, make a diagnosis and arrange for follow-up examinations that allow for incorporation of fax, e-mail or telephone exchanges of patient information. Respondent notes that while there have been uniform guidelines recommended and submitted to the California Medical Association (CMA), practice guidelines have yet to be adopted by the CMA or by the Board. Respondent views the protocols followed in making a Proposition 215 recommendation as quite different from those followed by a physician in making a prescription. He also believes that any treatment plan should address only the medical use of cannabis and not the patient's entire medical profile/condition. Respondent believes that the relevant practice standard should not require him to fully evaluate or treat every symptom present or suspected at the time the patient is evaluated.

This generally summarizes what the parties believe to be the correct practice models in making medical cannabis recommendations. In determining which governs, the appropriateness of the two models is best evaluated by considering the medical expert opinions offered in this case. The opinions relate directly to respondent's management of the sixteen patients referenced in the Second Amended Accusation and, accordingly, patient summaries and respondent's actions with respect to each patient are briefly outlined below.

A discussion of appropriate practice standards and whether or not respondent complied with them is incorporated within these discussions of each patient.

Patient R.A.

9. Patient R.A. was seen by respondent on March 5, 1997. Medical records include a Registration Form completed by Patient R.A., but two of the five pages from that form are missing. No other documentation reflects respondent's initial evaluation of this patient. There are no records reflecting the patient's medical complaints/health problems, medical/psychiatric history, physical/mental status examination or what advice was given by respondent. A Physician's Statement dated March 5, 1997, was issued indicating that Patient R.A. was under respondent's "medical care and supervision for the treatment of medical condition(s): Anxiety Disorder Gastritis." It also indicated that respondent had discussed the medical risks and benefits of cannabis use as a treatment and that he condoned the use of cannabis.

Patient R.A. completed a "Cannabis Patient Follow Up Visit Questionnaire" dated November 6, 1998. It indicated that marijuana had been used by him for treatment of gastritis/anxiety disorder. No psychiatric history, medical history, physical/mental status examination is recorded. Respondent noted "irritation from low potency" and "recounts stressors of arrest & case & involvement & insomnia" and that he discussed the effects on the patient's life. A Physician's Statement dated November 18, 1998, confirmed that Patient

R.A. was under respondent's "medical care and supervision" for "Gastritis Anxiety Disorder." Respondent also noted that Patient R.A. "Must return by 12-2-98 for follow up."

Patient R.A. completed a follow up questionnaire dated August 5, 1999, which reported treating complaints of anxiety disorder, gastritis and irritable bowel syndrome with marijuana, 15 to 38 grams/week. An "Illness status" category on the questionnaire was checked as "Stable". There were follow up visits on April 28, 2000, and on January 4, 2001. A progress note for April 28, 2000, noted increased anxiety and insomnia. The January 4, 2001 follow up questionnaire listed gastritis and anxiety as symptoms/conditions treated with cannabis and Patient R.A.'s illness status was marked as "Stable". Respondent noted that Patient R.A. planned on relocating to Holland secondary to his fear of continuing prosecution. R.A. did leave the country and respondent maintained contact with him. On March 12, 2001, respondent consulted with Patient R.A. by telephone. He reported increased anxiety, bowel symptoms/constipation, lumbosacral back pain and a 20 pound weight loss.

10. Complainant contends that respondent committed errors and omissions in the care and treatment of Patient R.A. by: 1) failing to evaluate his anxiety and insomnia complaints by means of a standard psychiatric history, medical history, physical examination and mental status examination; 2) failing to evaluate gastrointestinal complaints to rule out serious and perhaps life threatening illness while recommending palliative treatment; 3) failing to follow up on complaints and using a questionnaire that inappropriately lumped multiple complaints into a single illness category; 4) falsely and unethically representing that Patient R.A. was under his care and supervision for treatment of serious medical conditions; maintaining medical records that lacked adequate documentation of physical/mental status examination, clinical findings, vital signs, laboratory tests, follow-up and treatment plans necessary to an evaluation and diagnosis of the patient's condition, or to support the recommendation/prescription of any medication; and 6) furnishing marijuana without conducting a prior good faith examination and/or without medical indication.

11. Laura Duskin, M.D. testified as an expert witness on behalf of complainant. She is a psychiatrist with Kaiser Permanente, Adult Psychiatry Department, and a senior physician specialist, psychiatry with the San Francisco Department of Public Health, Community Clinics. Dr. Duskin is an Assistant Clinical Professor, UCSF School of Medicine. Her responsibilities there include teaching interviewing skills and diagnosis/treatment of psychiatric conditions to interns and residents at the medical school. Dr. Duskin is a Diplomate, American Board of Psychiatry and Neurology in Psychiatry (unlimited) and Geriatric Psychiatry. She has practiced psychiatry since 1983.

Dr. Duskin is familiar with the standard of practice for psychiatrists in both treating and consulting capacities. In terms of the initial patient evaluation she opines that the standard of practice is essentially the same, regardless of whether the physician is acting as a treating physician or as a consultant. She believes the standard of practice for recommending marijuana is identical to that governing any medication – mainly that the physician does an evaluation of the patient's complaints, formulates a differential diagnosis, discusses treatment options with the patient including the risks and benefits of medications, and

develops a treatment plan with provision for future monitoring. There is always an initial evaluation, some more comprehensive than others depending upon the status of the patient. When marijuana is being recommended for a psychiatric condition, the examination would include a mental status examination. This is basically an assessment of the patient's behavior, speech, reported mood, coherency, short term memory, impaired insight or judgment, thoughts of suicide or harming others, obsessive thoughts, etc. In some cases formal testing is required.

Where a psychiatrist is called upon to treat a condition that is non-psychiatric in nature the standard of practice is the same as that followed by any other physician, namely history, physical examination, differential diagnosis, appropriate treatment plan and plans for follow-up and responsibility for management of the problem unless it can be referred to the patient's primary care physician. Dr. Duskin emphasizes that this is really very basic, something all physicians learn as part of their medical school education. She makes specific reference to the Board's 1997 Action Report and to CSAM's policy statement (Finding 6) noting that they both merely confirm existing and accepted medical standards for treatment or prescribing of any medication.

Dr. Duskin notes that the standard of practice when treating patients in follow-up is to reevaluate the problem(s), the efficacy or problems with treatment, and to appropriately address any new concerns. If more than one condition is the focus of treatment, each condition is evaluated independently even if the same drug is being used to treat all of the conditions. Where referral for further evaluation and follow-up is warranted, a psychiatrist is responsible for making this referral and documenting this in the medical record. The standard of practice for medical records is for the psychiatrist to keep all records pertaining to the treatment of the patient, including prescriptions or certificates, and where copies of any portions of the medical records are provided to others, the psychiatrist retains the originals and sends copies only.

12. Dr. Duskin believes that respondent's treatment of Patient R.A. represented an extreme departure from the standard of practice in numerous areas of concern. The patient records contain no adequate initial evaluation note, no psychiatric or medical history, no mental status examination and no differential diagnosis. She notes that such lack of documentation for a patient for whom a psychoactive drug was being recommended was an extreme departure from the standard of care.

Dr. Duskin is critical of respondent's failure to document the history and make an appropriate follow-up plan for the patient's potentially serious gastrointestinal complaints. She is particularly concerned that "gastrointestinal cancer or other disease manifest with symptoms as described by this patient, and without appropriate medical evaluation the cannabis, if symptomatically effective, might only mask the problem until the disease progressed to a life threatening degree." There is no indication from the records that Patient R.A. was receiving ongoing treatment from another physician, important information that should be ascertained. If a physician is offering pain management or palliative treatment the physician is also responsible for making sure that the underlying problem is being addressed,

or that the patient is refusing to have that problem addressed. If such occurred in this case it was not documented and there is no indication that respondent discussed Patient R.A.'s medical or psychiatric treatment with any other health care provider.

Respondent used a patient questionnaire that allowed for illness status to be described in single word categories such as "stable", "improved" or "worse" and that grouped multiple conditions into a single evaluation category. Thus, on August 5, 1999, in reference to anxiety disorder, gastritis and irritable bowel syndrome that were being treated with cannabis, the reevaluation of the conditions consisted of the single word "stable". Dr. Duskin notes that when a symptom or condition is the focus of treatment, a one word description of the clinical situation is grossly inadequate, and that no competent clinician would lump multiple conditions into an illness category and evaluate them together as one.

In follow-up evaluations it was noted that the patient had increased anxiety and insomnia on April 28, 2000, and on March 12, 2001. No evaluation of these symptoms was documented and no treatment plan other than to recommend cannabis was made. Dr. Duskin allows that cannabis may have been efficacious for these problems but given the ongoing nature of the problems "further evaluation and consideration of supplemental treatment with other medications, other treatment modalities or a complete change in treatment for these conditions was clearly in order." Dr. Duskin is also critical of the length of time between follow-up contacts and the lack of an interval history of the progress of the patient's conditions between contacts.

Dr. Duskin has additional concerns that respondent provided a certification indicating that the patient was under his "care and supervision," something she characterizes as false and misleading. She notes, for example, that the patient's gastritis was not being followed in any way in a manner that would be expected if he was under respondent's care and supervision for that condition.

13. Respondent did not view himself as R.A.'s primary care physician and avers that he only rendered a diagnosis sufficient for the purpose of determining that R.A. had a serious and chronic condition that was helped by marijuana. He contends that R.A. was under his care and treatment because he had seen him frequently and stayed in telephone contact and followed his condition even after he left the country. He believes that he conducted a bona fide examination in determining that R.A.'s condition was both serious, chronic and helped by cannabis. He attributes R.A.'s symptoms (psycho-physiologic gastrointestinal dysfunction) to R.A.'s anxiety related to law enforcement. He disagrees that he failed to evaluate R.A.'s gastrointestinal complaints to rule out more serious disease, dismissing the notion that marijuana was palliative treatment at all.

14. Philip Andrew Denney, M.D. testified as an expert witness on behalf of respondent. He attended the University of Southern California School of Medicine and has been in medical practice since 1976. Recent professional activities include positions as the Facility Medical Director of Meridian Occupational medicine Group, Sacramento (1996-97); Facility Medical Director of Healthsouth Medical Clinic, Rocklin (1997-99); Medical

Director, Marshall Center for Occupational Health (1999-2000); and Occupational and Legal Medicine (2000 – present). From 1999 his medical legal practice has included medical cannabis recommendations. Dr. Denney's membership in professional societies includes the American College of Occupational and Environmental Medicine and the California Cannabis Research Medical Group. He remains informed about medical cannabis from the small universe of practitioners in this field who exchange information informally or through organized conferences. He describes one of respondent's publications as an authoritative and seminal work that introduces western physicians to appropriate citations in medical literature in this field. Although he believes thousands of doctors give cannabis recommendations, Dr. Denney notes that fewer than twenty consult on medical cannabis issues as a primary part of their practice. He falls within this category.

Dr. Denney views respondent's role as that of a consultant, and not as that of a treating physician. Because cannabis cannot be prescribed he notes that the physician is not involved in treatment at all, rather the patient is engaged in self treatment of a medical condition. The physician's role is that of recommending the cannabis for a medical condition. The physician is not saying that this is the sole treatment, it may be only one small part. Dr. Denney believes that the good faith examination required in these cases is only that which is necessary to gain the information needed. He considers the Board's 1997 Action Report to be advisory in nature and not the standard of practice.

With regard to Patient R.A., Dr. Denney opines that cannabis has salutary effects on gastritis but would not mask a more serious condition. He describes its effects as very mild compared to other prescription drugs, opiates for example. He has no criticism of respondent's medical records or lack thereof. Dr. Denney notes that it is not uncommon to have cursory, largely unintelligible and useless information contained in medical records. In making a sincere medical judgment he believes physicians rely more on actual observations and face to face contact with patients, and not upon medical records or other written documents provided by the patient.

15. Dr. Denney acknowledges obtaining a patient's history and performing physical examinations in his own practice, including medical cannabis consultations. He explains that he does so primarily for administrative and legal reasons yet he has consistently taken this examination approach for patients over his entire career in an effort to practice "excellent medicine." During medical cannabis evaluations he investigates complaints raised by the patient and if warranted he advises patients to seek follow-up care. He documents such discussions in his medical records. Dr. Denney opines that respondent is a superb physician whose medical cannabis practices were both appropriate and within the standard of care. Yet Dr. Denney's own practices are very different from respondent's and his practices are entirely consistent with the Board's 1997 Action Report policy statement. In conducting his medical cannabis evaluation Dr. Denney obtains a medication history and reviews the reason for using cannabis. He discusses medical cannabis and any problems with its use with the patient, reviews any available records and tries to determine whether the patient is being truthful. He conducts a "head to toe" physical examination and evaluates the presenting complaint for each patient. Dr. Denney notes that if a patient raises a complaint of

importance he would "certainly" advise the patient to seek follow-up care with a physician. He acknowledges that it is important to keep medical records documenting the medical evaluation, and that such records might be important to subsequent treating physicians.

Essentially, the good faith examination Dr. Denney performs to support a recommendation for medical marijuana is no different than what he follows in any other medical evaluation.[5] It is also consistent with the standards articulated by Dr. Duskin.

16. The above matters having been considered, it does appear that the standard of practice for conducting a medical cannabis evaluation is identical to that followed by physicians in recommending any other treatment or medication. The standard applies regardless of whether the physician is acting as a treating or as a consulting physician. The medical cannabis evaluation is certainly focused on the patient's complaints, but it does not disregard accepted standards of medical responsibility. These standards include history and physical examination of the patient; development of a treatment plan with objectives; provision of informed consent; periodic review of the treatment's efficacy and proper record keeping. When a cannabis recommendation is being made for a psychiatric condition the examination would additionally entail a mental status examination to establish a psychiatric diagnosis and severity of the condition. In such cases a physical examination might not be included, or might only include a limited physical examination appropriate to the clinical situation. In sum, the standard of practice for a physician recommending marijuana to a patient is the same as pertains to recommending any other treatment or medication.

Respondent contends that consulting physicians would be unreasonably burdened with conducting a complete work up on each conceivable diagnosis or symptom presented or suspected and that he would have to maintain extensive notes on every item of communication between physician and patient. He is also concerned that he would be responsible for referring patients out for additional medical care if not provided personally and that patients would be required to return for further evaluations and extensive testing to independently verify medical diagnoses or symptoms.

A physician must obviously exercise some discretion in making clinical judgments and it would be unreasonable to require a comprehensive physical/mental examination in every case. Complainant's major criticism of respondent is that he failed to perform any work up on each patient's chief presenting complaint and that he failed to conduct even the most cursory of physical or mental status examinations. Dr. Denney's practice is instructive because, like respondent, he also performs numerous medical cannabis evaluations. Yet he incorporates traditional elements of a medical evaluation and the examination that he

[5] Dr. Denney acknowledged in prior testimony that he makes a determination of whether a patient should be given a prescription or some kind of treatment as follows: "I take a medical history. I examine the patient. I do a physical examination. I base my opinion on those things, on records if they're available, on my opinion as to the patient's truthfulness, etc." When asked what is a recommendation for cannabis he answered: "A recommendation is an opinion based upon history and physical exam and experience that says that the patient has a condition which in the physician's opinion will benefit from cannabis use." (*People* v. *Urziceneau*, Sacramento Superior Court No. 00F06296.)

undertakes is the same that he performs on all his patients. The model is not as rigid or as burdensome as respondent suggests. Dr. Duskin allows for flexibility, noting for example that no physical examination or only a limited physical examination may be appropriate in cases where medical marijuana is recommended for a psychiatric condition. When warranted, it hardly seems burdensome at all to refer a patient out for additional evaluation or care if one is not the treating physician and a serious condition is suspected or confirmed. Failure to do so is an extreme departure from the standard of care.

17. It was established that respondent committed errors and omissions in his care of Patient R.A. in the following respects:

a. Respondent failed to evaluate R.A.'s gastrointestinal complaints, anxiety, and insomnia by means of a standard medical history, physical examination and mental status examination. Medical records for R.A. lacked adequate documentation of physical examination, clinical findings, vital signs, mental status examination, test results and treatment plan. Such failures constituted an extreme departure from the standard of care.

b. Respondent failed to evaluate or refer R.A. out for evaluation of gastrointestinal complaints to rule out serious and perhaps life threatening illness and such constituted an extreme departure from the standard of care.

c. Respondent failed to follow-up on R.A.'s complaints and used an inadequate check box questionnaire that lumped multiple complaints together into a single illness category. It was designed to be completed by the patient. The lumping of multiple complaints into a single illness category is a matter of poor questionnaire design, a departure from the standard of care.

d. Respondent falsely represented that R.A. was under his care and supervision for treatment of a serious medical condition. The choice of language on respondent's Physician Statement was intended to assist the patient in certifying eligibility under Proposition 215, no more. It was boilerplate and the form was designed by respondent at a time when there was little guidance on appropriate language to be used. Under these circumstances it reflected a departure from the standard of care.

Patient S.A.

18. Patient S.A., a 20 year old male, was seen by respondent on May 20, 1996. He reported a history of nausea, vomiting, motion sickness and anorexia. Medical records indicated that he had previously been worked up by physicians with an upper GI exam showing "probable small duodenal ulcer." Respondent's medical records for S.A. contain no

documentation that he elicited a history of other medical conditions, that he took vital signs or that he performed a physical/mental status examination. No treatment plan was formulated and there was no plan for follow-up of the patient's continuing gastrointestinal problems. Respondent did prescribe Marinol, a pharmaceutical containing the active ingredient in marijuana, for the patient's symptoms.

On November 10, 1997, respondent noted that the Marinol provided less relief than crude marijuana and based upon the patient's statement that he was "doing well with symptom control" respondent issued a Physician Statement indicating that S.A. was under his medical care and supervision for the serious medical condition of gastritis and that respondent recommended marijuana for this condition.

On May 12, 1998, S.A. requested a renewal of his Marinol prescription. The communication was characterized as a "televisit" and the patient's gastritis was described by a box checked "stable." A note on the form indicates that the certificate was mailed to the patient.

On October 16, 1999, the patient again requested a "renewal of cannabis recommendation." The communication was not in person, but was conducted via fax transmittal of a "Cannabis Patient Follow Up Visit Questionnaire." The form contains the patient's assessment that his gastritis was "stable" and his nausea was "better." S.A. also checked the box indicating that he found the treatment to be "very effective" and answered "no" to the question whether he experienced adverse effects. He issued the cannabis recommendation after he received the follow-up questionnaire and requested fee.

19. Dr. Duskin notes that S.A. was first seen by respondent approximately three years after he was diagnosed with a possible duodenal ulcer and that it was incumbent upon him to obtain an interim history to determine whether disease progression or some other gastrointestinal problem could account for current symptoms. Vital signs, frequency of vomiting, loss of blood and weight loss would all have been basic parts of a medical evaluation in this case. No vital signs or patient weight were recorded by respondent. On the basis of the patient's verbal reports, respondent justified a diagnosis of "gastritis, rule out peptic ulcer." Respondent prescribed Marinol without documenting informed consent and there is no indication that he referred S.A. back to his gastroenterologist or primary care provider for further evaluation. During his initial visit respondent noted that S.A.'s chemistry panel was within normal limits.

Two of the three follow-up visits were not face to face meetings. The standard of practice for follow-up visits is for the physician to reevaluate the clinical complaint(s) and any new problems. This entails an interval history of the symptoms or condition. A one word statement ("Stable") checked on a form by the patient is not sufficient information upon which to make a clinical decision to continue Marinol. A medication renewal to treat gastritis, nausea and motion sickness would necessitate a clinical evaluation of the patient or documentation that an appropriate clinical evaluation was done by another practitioner prior to renewing the medication. A doctor might renew a prescription for a brief period without

seeing a patient if the patient had been seen recently, but in this case respondent issued a cannabis recommendation on October 29, 1999, more than seventeen months after his previous evaluation. It appears that respondent issued the cannabis recommendation only after he received the follow-up questionnaire and requested fee. Dr. Duskin opines that "to charge for what amounts to a medication renewal without reevaluating the patient is unethical and grossly inappropriate. Likewise, this action would constitute an extreme departure from the standard of practice from a clinical standpoint."

Respondent signed a statement indicating that S.A. was under his "medical care and supervision" for the treatment of gastritis. If this were the case respondent would have been coordinating the ongoing evaluation and treatment of this condition with the patient's gastroenterologist or other medical practitioner and this was not the case.

20. Respondent notes that he evaluated S.A. only for a medical marijuana recommendation and that for purposes of follow-up, telephone contact and questionnaire were sufficient. He did not see himself as the primary care physician, noting that S.A. was self treating with cannabis before he saw respondent. Respondent believes that he performed a bona fide examination on the initial as well as on follow-up evaluations. He acknowledges that he did nothing to rule out peptic ulcer or to work up the gastritis. His focus was on determining eligibility under the Compassionate Use Act. When asked if he would be concerned if S.A. did not have a physician he answered in the negative, noting that it was not his responsibility and that it was beyond the scope of a consultative exam.

21. It was established that respondent committed errors and omission in the care and treatment of Patient S.A. in the following respects:

a. Respondent failed to evaluate S.A.'s gastrointestinal complaints by means of a standard medical history, physical examination. Medical records for S.A. lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan. He prescribed Marinol without ruling out progression of the previously suspected duodenal ulcer. Such failures constituted extreme departures from the standard of care.

b. Respondent failed to re-evaluate or refer S.A. out for evaluation of gastrointestinal complaints to rule out serious illness and such constituted an extreme departure from the standard of care.

c. Respondent renewed S.A.'s recommendation in 1998 and 1999 without an interval history of the patient's condition and with the last examination not having been performed since November 1997.

d. Respondent charged S.A. for medication renewal without conducting an examination, an extreme departure from the standard of practice.

Patient J.B.

22. Patient J.B., a 40 year old female, was seen by respondent only once, on August 9, 1997. She presented with a ten year history of chronic depression and anxiety.

He diagnosed her with dysthymic disorder and Post Traumatic Stress Disorder (PTSD).

Dr. Duskin opines that respondent's treatment represented an extreme departure from the standard of practice when he failed to evaluate her symptoms of anxiety, depression and panic attacks. Respondent did not obtain the requisite history of the onset and duration of the patient's complaints, nor did he determine whether the patient had ever been hospitalized or ever been suicidal. He conducted a mental status examination that Dr. Duskin believes was deficient because it provided information only about the patient's current state and nothing about her history. Further, he did not offer her standard treatment for these diagnosed conditions when many effective treatments are available for both PTSD and dysthymia. The medical records contain no documentation that he offered standard treatment for these conditions or that if he did that the patient refused. Dr. Duskin also opines that he inappropriately instructed her to follow-up with him as needed instead of establishing a follow-up plan given the severity of her psychiatric conditions. Dr. Duskin has no quarrel with the cannabis recommendation, only with respondent's failure to do more. She emphasizes that a treatment plan in this case would need a number of elements – life circumstances needed to be addressed, and consideration given to behavioral interventions and perhaps adjunctive medications. Respondent issued a statement indicating that J.B. was under his "medical care and supervision" for dysthymic disorder and PTSD and this simply was not the case.

Respondent views his role in this case as that of providing J.B. with medicinal justification and protection from law enforcement. His understanding is that a clinical evaluation is a visit where a clinical decision is made and he believes he conducted a bona fide examination in this case. He avers that he spent over an hour with this patient. He does not know if J.B. had another physician and notes that she was opposed to taking pharmaceuticals making treatment options and interventions limited. He did not refer her to therapy or to another physician. Respondent believes the scope of the consultative evaluation was to issue her a certificate even though he felt that she needed much more.

23. It was established that respondent committed errors and omissions in the care and treatment of J.B. in the following respects:

a. Respondent conducted an inadequate evaluation of her symptoms of depression, anxiety and panic attacks.

b. Respondent arrived at a diagnosis of PTSD and dysthymic disorder without conducting a documented clinical evaluation.

c. Respondent failed to offer or refer J.B. out for standard psychiatric treatment for her conditions.

d. Respondent failed to provide follow up care for J.B.'s complaints.

Respondent's overall treatment of J.B. as above described represented an extreme departure from the standard of care.

Patient J.M.B.

24. On December 30, 1998, Patient J.M.B., a 26 year old male, consulted respondent for complaints of chronic pain that he attributed to spinal injuries sustained in prior automobile accidents. Respondent's records contain no vital signs physical examination or other medical evaluation of the patient's spinal complaints. Respondent issued a physician's certificate stating that J.M.B. was under his medical care and supervision for the treatment of intervertebral disc disease. A physician evaluating a patient with chronic orthopedic complaints is required to perform a physical examination, to obtain a history of the patient's condition, to assess any decrease in range of motion and limitations in daily activities. Respondent did none of these things.

On June 22, 1999, respondent issued a physician's statement to J.M.B. reiterating that he remained under respondent's care and supervision for the treatment of intervertebral disc disease. There is no record that respondent re-evaluated J.M.B. on this date, nor is there any evidence that respondent obtained an interval history.

Respondent believes he performed a bona fide examination for purposes of recommending medical cannabis. When asked whether a physical examination might have assisted in verifying complaint he explains that in most cases he takes what a patient says to be true and accurate.

25. It was established that respondent committed errors and omissions in the care and treatment of J.M.B. in the following respects:

a. Respondent failed to evaluate J.M.B. for intervertebral disc disease and arrived at a diagnosis without performing appropriate medical work up. Such failure constituted an extreme departure from the standard of care.

b. Respondent renewed the patient's recommendation without interval history or re-evaluation, an extreme departure from the standard of care.

c. Respondent's statement that J.M.B. was under his medical care and supervision for intervertebral disc disease was false, a departure from the standard of care.

Patient R.B.

26. Respondent saw R.B., a 27 year old male, on May 21, 1999. R.B. presented with complaints of nausea and dizziness and respondent made diagnoses of nausea and alcohol-related gastritis. In doing so he recorded no vital signs and ordered no laboratory tests. Medical records do not document any history, physical examination or other appropriate methods by which respondent arrived at a diagnosis. Dr. Duskin opines that respondent's treatment of R.B. "represented an extreme departure from the standard of practice when he made two diagnoses without obtaining an adequate medical history e.g. review of the onset, course of illness, alleviating and exacerbating factors in enough detail to make an accurate diagnoses."

R.B. did bring medical and other records, 40 pages worth, with him to his examination with respondent along with his medications. He had a primary care physician with Kaiser and had undergone extensive medical work-up and treatment prior to being seen by respondent. R.B. indicated that he was told that Kaiser would not permit its doctors to sign Proposition 215 recommendations and that was why he sought out respondent.

Respondent notes that he reviewed the records that R.B. brought with him and that he examined him. This included a family and past medical history, present illness, treatment plan and a review of cannabis use pattern. Respondent believes vital signs and laboratory tests were irrelevant in that they have nothing to do with the specific question of whether medical cannabis is appropriate. He acknowledges that he does not take vital signs, including blood pressure, for any of his patients. He notes that he conducted a bona fide examination of R.B.

27. It was established that respondent diagnosed R.B. with nausea and gastritis without performing a physical evaluation, recording vital signs or ordering laboratory tests.

Medical records for R.B. lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan. Such failures constituted extreme departures from the standard of care. It was not established that respondent failed to take an adequate history given the information that R.B. provided to him via patient records and clinical interview.

Patient D.B.

28. Respondent saw D.B. on June 26, 1998, with complaints of cerebral palsy and post-traumatic arthritis. No physical examination and no vital signs were recorded. On June 27, 1998, respondent issued a recommendation for the patient's medical cannabis use and indicating that D.B. was under his medical care and supervision for the treatment of cerebral palsy and post-traumatic arthritis. There were no treatment goals and no baseline data upon which progress could be measured. By the time of a follow-up evaluation on January 21, 2000, there were still no records of any kind, nor any type of appropriate referral for medical reevaluation of the physical condition of concern. D.B. was charged $100 for "confirming

status" without any apparent examination. Dr. Duskin notes that even though cannabis was reportedly beneficial to the patient "other adjunctive treatments would need to be explored including possible medication, physical therapy, occupational therapy for assistive or corrective devices, etc." Just addressing the cannabis portion of treatment did not amount to "medical care and supervision."

It was established that respondent committed errors and omissions in the care and treatment of D.B. in the following respects:

a. Respondent recommended treatment to D.B. without conducting a physical examination. Medical records for D.B. lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent failed to provide follow up or referral for the patient's complaints.

c. Respondent charged for renewal of the patient's recommendation even though no examination was performed.

d. Respondent's statement that D.B. was under his medical care and supervision for cerebral palsy and traumatic arthritis was false.

Respondent's overall treatment of D.B. as above described represented an extreme departure from the standard of care.

Patient K.J.B.

29. Respondent first saw K.J.B., a 42 year old male with complaints of muscle spasm and lumbosacral pain, on August 24, 1998. There is no record of a physical examination of the patient, nor is there a proposed treatment plan or plan for follow-up. Respondent issued a physician statement indicating that K.J.B. was under his medical care and supervision for the treatment of Lumbosacral Disease. On September 20, 1999, K.J.B. again contacted respondent and on that occasion he provided respondent with a Beck Inventory, a self-administered questionnaire that is used to measure the degree of a patient's depression. K.J.B. endorsed a number of items and multiple statements indicating a significant level of depression. K.J.B. also completed a form indicating that he suffered from depression, insomnia, weight loss, cannabis addiction and back pain. There is no recorded assessment by respondent of the patient's multiple complaints and there was no plan for treatment or follow-up for the patient's depression and back pain except for a box indicating follow-up in 6 – 12 months.

The standard of practice for treating musculoskeletal pain and muscle spasm is to take an adequate history, do a pertinent physical examination, obtain old records when available, make or confirm the diagnosis, and develop a treatment plan presenting all reasonable

treatment options and making referrals as appropriate. The same standard applies to treating depression except that the examination would consist of a mental status examination and pertinent parts of the physical examination. In this case there was not an adequate evaluation of either the psychiatric or the musculoskeletal complaints.

K.J.B. believed that respondent was his treating psychiatrist and was the "best" in the field and it is therefore troubling that respondent indicates that he did not perform a formal mental status examination and that K.J.B. was mistaken if he believed that he was his psychiatrist. Dr. Duskin notes that though cannabis may have helped in the patient's depression, there are many effective treatments for depression including both antidepressants and psychotherapy, treatments that respondent failed to provide or refer out for. Respondent avers that he did not suggest therapy or standard treatment for K.J.B. because he believed K.J.B. was not the sort of person who would be accepting of therapy.

30. It was established that respondent committed errors and omissions in the care and treatment of K.J.B. in the following respects:

a. Respondent failed to conduct a physical examination of K.J.B. before recommending treatment. Medical records for K.J.B. lacked adequate documentation of physical/mental status examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent failed to conduct an evaluation of the patient's depression.

c. Respondent failed to reevaluate the patient in light of the patient's continuing depression or to consider alternative treatments for the patient's recurrent depression.

d. Respondent's statement that K.J.B. was under his medical care and supervision for lumbosacral disease was false.

Respondent's overall treatment of K.J.B. as above described represented an extreme departure from the standard of care.

Patient J.C.

31. Respondent saw J.C., an 18 year old female, on December 11, 1998. She complained of anorexia and stated that she was 6 months pregnant and had used marijuana to keep food down. Donnatal and over-the-counter medications were apparently ineffective. Dr. Duskin opines that such complaints in pregnant patients are potentially serious for the patient and for the fetus. The standard of care requires that a physician evaluate, first, the type of anorexia that is being addressed and include a description of the patient, her weight, vital signs and a detailed history. Respondent failed to record the patient's height, weight or vital signs and no history relevant to the patient's anorexia is documented, nor is a history documented with regard to his diagnosis of prolonged traumatic stress disorder. There is no

record of discussion of the relative risks and benefits of marijuana use. Dr. Duskin believes the failures above described were simple departures from the standard of care, but given the multiple simple departures represented an extreme departure.

J.C. and her mother both testified. As soon as J.C. began using cannabis she began to gain weight and her pregnancy was a healthy one. She provided a substantial number of patient records to respondent that he reviewed at the time of his evaluation. Respondent is criticized for his failure to contact J.C.'s treating obstetrician, but he explains that J.C.'s mother told him that the obstetrician approved of her daughter receiving cannabis but was afraid to provide a written recommendation. Under the circumstances respondent believed it unnecessary to contact this physician. Respondent also recommended cannabis instead of Marinol because he believed that J.C.'s stomach would be too sensitive and that through vaporization technique J.C. would be able to inhale therapeutic resins without other contaminants.

32. It was established that respondent committed errors and omissions in the care and treatment of J.C. in the following respects:

a. The medical records for J.C. lacked adequate documentation of physical/mental status examination, clinical findings, vital signs, test results and treatment plan.

b. He failed to work up J.C. prior to arriving at a diagnosis of prolonged traumatic stress disorder.

Respondent's overall treatment of J.C. as above described represented an extreme departure from the standard of care. However, it was not established that he failed to adequately evaluate J.C.'s reported anorexia given the amount of information about her condition that was made available to him. Similarly, it was not established that he failed to consider alternatives to smoked marijuana for J.C. His decision not to prescribe Marinol was based on his reasonable clinical judgment that her stomach would not be able to tolerate this medication. Respondent also provides a reasonable explanation for his decision not to contact J.C.'s treating physician.

Patient S.F.

33. Patient S.F. was 16 when she saw respondent on March 18, 1999, complaining of migraine headaches, depression and painful menstrual cramps that had worsened following a therapeutic abortion. She had no treating physician and had received no medical work up for any of these conditions. Her reported history included stress and "flipping out" during periods of extreme anger. Respondent recorded no history regarding the headaches. No physical or mental status examination and no vital signs are documented in the records. Respondent issued a physician's statement indicating that S.F. was under his medical care and supervision for the treatment of migraine headache and premenstrual syndrome.

Dr. Duskin agrees that marijuana might be helpful for these complaints but notes that respondent took only a partial history from S.F. regarding her headaches and did not adequately assess their triggering factors, duration and progression. Regarding the complaints of persistent and severe menstrual cramping, the standard of care would require an evaluating physician to obtain a history, including cycle, where in the cycle the symptoms are occurring, whether the menses are heavy or light, as well as what has helped or aggravated the condition. Infertility issues should be considered for a patient this young with a history of therapeutic abortion and referral for gynecological examination was indicated.

S.F. reported past medical history of depression, stress and head injuries and there is no indication that respondent undertook an evaluation of these conditions. The standard of practice upon hearing that a patient has had a head injury is to do a full history and neurological examination, or arrange for same.

34. Respondent relied upon information provided to him by S.F. and her father. He believes that he did an adequate work up regarding the etiology of the headaches and he determined that the head injury had occurred some time in the distant past and that she had recovered with diminishing sequela. He made a specific recommendation for psychological evaluation to S.F. and to her father. There were significant behavior problems at issue in their home.

35. It was established that respondent committed errors and omissions in the care and treatment of S.F. in the following respects:

a. Respondent failed to adequately work up the etiology and nature of S.F.'s headaches. The medical records for S.F. lacked adequate documentation of physical/mental status examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent failed to evaluate the patient's complaints of painful menstrual cramps and failed refer her to an obstetrician/gynecologist for further evaluation.

c. Respondent's statement that S.F was under his medical care and supervision for treatment of migraine headaches and premenstrual syndrome was false.

Respondent's overall treatment of S.F. as above described represented an extreme departure from the standard of care. However, it was not established that respondent failed to address her stress and depression or that he failed to make a counseling or psychotherapy referral. He did so. He also made a clinical determination that her head injury was not recent and that she had recovered with no ill effects.

Patient D.H.

36. Respondent saw D.H., a 36 year old female, on April 30, 1999. She complained of very painful headaches as well as neck and shoulder pain associated with stress. Respondent issued a recommendation for the patient to use marijuana for tension headaches, pruritus and anxiety disorder. Medical records for D.H. contain no record of physical examination, vital signs, mental status examination or other work up of her complaints. The records consist largely of a questionnaire completed by the patient. There is no written evaluation by respondent.

Dr. Duskin opines that respondent failed to conduct an adequate history and physical examination to make or confirm the diagnoses presented by D.H. This was particularly important for headache complaints given the different causes and the need for a physician to develop a treatment plan specific to the cause of headache symptoms.[6] D.H. brought with her to her appointment medical reports and evidence of her condition. She told him that she had benefited from the use of cannabis in that her headaches were less intense and the itching was not as bad. She had a primary physician and had also been to a chiropractor and respondent advised her to also follow what her other doctors had recommended.

37. It was established that respondent committed errors and omissions in the care and treatment of D.H. in the following respects:

a. Respondent failed to adequately work up the etiology and nature of D.H.'s headache complaints and, aside from recommending marijuana, did not develop a treatment plan for her. The medical records for D.H. lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent failed to document and evaluate D.H.'s complaints of pruritus and, aside from recommending marijuana, did not develop a treatment plan for her.

c. Respondent failed to document and evaluate D.H.'s complaints of anxiety and, aside from recommending marijuana, did not develop a treatment plan for her.

d. Respondent's statement that D.H. was under his medical care and supervision for treatment of headaches, pruritus and anxiety was false.

Respondent's overall treatment of D.H. as above described represented an extreme departure from the standard of care.

[6] Causes may include benign conditions as tension headache, uncorrected vision problems, teeth clenching and migraine, to much more serious conditions such as carbon monoxide poisoning, subdural hematoma or even brain tumor.

Patient J.K.

38. Respondent issued a physician's statement dated July 23, 1999, indicating that J.K., a 37 year old year old male, was under his care and supervision for posttraumatic stress disorder and traumatic arthritis. J.K. completed a questionnaire dated June 27, 1999, describing his present illness as dysthymic disorder and steel pin in right leg. Respondent's records contain no record of psychiatric history, physical examination, vital signs, mental status examination or other work up of the patient's complaints. The standard of practice for a psychiatrist evaluating a patient with a history of dysthymia is to complete a psychiatric history and to perform a mental status examination to determine the degree of depression. In diagnosing PTSD the standard of practice is to determine whether the diagnosis is justified in light of symptoms and history. Dr. Duskin opines that respondent's treatment represented an extreme departure from the standard of practice when he diagnosed PTSD without specifying any of the symptoms/criteria necessary for this diagnosis.

Respondent avers that he learned sufficient medical history from this patient to indicate that he suffered from these conditions but acknowledges that documentation supporting PTSD was not present. With regard to traumatic arthritis, he believes that the fact of an indwelling pin indicates serious trauma with consequent arthritis.

39. It was established that respondent committed errors and omissions in the care and treatment of J.K. in the following respects:

a. Respondent failed to evaluate J.K.'s reported depression by obtaining a psychiatric history and mental status examination. The medical records for J.K. lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent diagnosed J.K. with PTSD without specifying the symptoms or criteria requisite to that diagnosis.

c. Respondent failed to evaluate J.K. for traumatic arthritis by appropriate history and examination.

d. Respondent's statement that J.K. was under his medical care and supervision for treatment of PTSD and traumatic arthritis was false.

Respondent's overall treatment of J.K. as above described represented an extreme departure from the standard of care.

Patient D.K.

40. D.K., a 54 year old female, was seen by respondent on June 27, 1998, with a history of stroke and tobacco dependence. Respondent issued a physician's statement representing that D.K. was under his medical care and supervision for brain trauma and nicotine dependence. Other than that which was apparent through observation, respondent did not conduct an evaluation of her brain trauma nor did he evaluate her tobacco smoking addiction. Dr. Duskin opines that the standard of practice when treating symptoms associated with prior brain injury is to specifically identify the symptoms, onset, intensity, exacerbating and relieving factors, and effectiveness of past treatments. Though cannabis might be very effective for symptoms of brain trauma, other psychotropic medications may be equally or more effective and the patient needs to be made aware of therapeutic options. Dr. Duskin recognizes the value of cannabis being of assistance in a harm reduction treatment of nicotine dependence but notes that the standard of practice requires obtaining a smoking history (pack years, recent history including attempts to quit, etc.) and discussing treatment options.

Respondent notes that D.K. was specifically seeking recommendation for use of medical cannabis that she had found useful for symptoms of organic brain damage she suffered at age 21. He observed her peculiar speech patterns, that she was emotionally labile, depressed and had difficulty controlling her reactions. Cannabis helped her become less agitated and less disorganized. He felt that he was able to adequately evaluate her brain injury and determine that it was a serious chronic condition that would be helped by cannabis. His response to criticism of his practice regarding evaluation, diagnosis and treatment plans is that these were matters beyond his role as a medical cannabis consultant and that he had all the information that he needed to determine whether D.K. had a condition that would benefit from the use of marijuana. Respondent believed that she would also benefit from neuropsychological testing and possible eligibility for public rehabilitation programs. He issued a written recommendation for such testing.

D.K. returned to see respondent on July 24, 1999, and July 28, 2000, and records consist largely of a questionnaire completed by the patient indicating status by checked categories on the form that lumped multiple serious conditions together.

41. It was established that respondent committed errors and omissions in the care and treatment of D.K. in the following respects:

a. Respondent failed to evaluate D.K.'s brain injury, failed to establish a diagnosis of the patient's condition and failed to develop a treatment plan. The medical records for D.K. lacked adequate documentation of physical/mental status examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent failed to evaluate D.K.'s nicotine dependency and to document her tobacco smoking history.

c. Respondent failed to conduct an appropriate follow-up evaluation for D.K.'s condition and charged for renewal without reexamining her.

d. Respondent's statement that D.K. was under his medical care and supervision for treatment of brain trauma and nicotine dependence was false.

Respondent's overall treatment of D.K. as above described represented an extreme departure from the standard of care.

Patient E.K.

42. Respondent saw E.K., a 49 year old male with complaints of insomnia and back pain, on February 17, 1997. He reported that he had a back pain since age 18 secondary to scoliosis and that he had been using marijuana to relieve pain symptoms. He also reported a history of hypertension. No physical examination is documented and no vital signs were recorded. Respondent prescribed Marinol.

On March 17, 1999, E.K. completed a follow-up questionnaire indicating a desire to replace Marinol with crude marijuana. He sought marijuana for conditions of "sleep, hypertension, blood pressure, blood sugar, eating." Respondent charged E.K. $120 and sent him a recommendation for the use of marijuana for anxiety disorder and persistent insomnia. E.K. contacted respondent in March 2000 and March 2001, and received recommendation renewals, all without examination. The recommendations indicated that E.K. was under his care and supervision for anxiety disorder, insomnia and essential hypertension, except that the 2001 statement omitted the reference to hypertension. No explanation is documented for this change.

Dr. Duskin notes that the standard of practice for a psychiatrist evaluating a patient with these conditions is to evaluate each condition and develop a treatment plan specific to each. She opines that his treatment of E.K. constituted an extreme departure from the standard of practice because he failed to evaluate the patient insomnia and anxiety in even a basic way – type, severity, duration, accompanying symptoms, exacerbating and alleviating factors. He also failed to evaluate the blood sugar and blood pressure complaints, not even taking a blood pressure reading or ordering or referring him for appropriate laboratory tests that are routine in the evaluation of a hypertensive patient.

Respondent explains that E.K. sought no more than a cannabis recommendation from him, that he conducted a sufficient examination, that he determined that the conditions were both serious and chronic and by E.K.'s account relieved by cannabis. He notes that E.K. is a Christian Scientist and his personal/religious beliefs precluded him from consultation with most physicians. Respondent did not believe he was being consulted for hypertension or high blood sugar and notes that they were conditions that were mentioned in passing. Yet, respondent listed hypertension as a condition for which E.K. was under his care and supervision and that cannabis was recommended for same.

43. It was established that respondent committed errors and omissions in the care and treatment of E.K. in the following respects:

a. Respondent failed to evaluate E.K.'s hypertension, fluctuating blood sugar and complaints of anxiety and insomnia. The medical records for E.K. lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent's statement that E.K. was under his medical care and supervision for treatment of anxiety disorder, insomnia and essential hypertension was false.

c. Respondent dropped his diagnosis of essential hypertension without documenting normalization of the patient's blood pressure.

d. Respondent charged for renewal of recommendation without re-examining the patient.

Respondent's overall treatment of E.K. as above described represented an extreme departure from the standard of care.

Patient F.K.

44. Respondent saw F.K., on June 30, 1997, for complaints of alcohol dependency and lumbosacral radiculitis. His diagnosis for F.K. was thoracic or lumbosacral neuritis or radiculitis, unspecified and alcohol dependence syndrome, unspecified. He documented no mental status examination, no adequate medical, psychiatric or substance history, no physical examination to evaluate the lumbosacral problem and no treatment plan other than to discontinue alcohol. Respondent issued a physician's statement indicating that F.K. was under his care and treatment for lumbosacral thoracic radiculitis and alcoholism. Dr. Duskin opines that the standard of practice when diagnosing substance abuse or dependence is to document the substance abuse history, psychiatric history, perform a mental status examination and perform relevant physical examination and laboratory tests. A treatment plan addressing the problem should be stated in the medical record. She notes that respondent's evaluation seemed to consist only of references to three glasses of wine per week and this was inadequate. A mental status exam is needed to assess whether there is a primary or secondary psychiatric problem associated with the substance abuse. Simply informing a patient that he should "stop drinking" is not sufficient treatment.

Patient F.K. brought with him Veterans Administration (V.A.) medical records to his initial interview and they were reviewed by respondent. He had begun self-medicating with marijuana well before this meeting. It eased his back pain. V.A. physicians told him they could not recommend medical marijuana but also told him that respondent was an expert. F.K. prefers not to use opiates. In the past he drank a six pack and a couple of glasses of wine daily after work. He drinks a single glass per day with dinner if he is using marijuana.

Respondent believes he adequately evaluated F.K.'s drinking problem and that he engaged in thorough telephonic interviews for all follow-up evaluations. Telephone contacts were on March 5, 1998, November 24, 1998, and July 25, 2001. They typically lasted up to fifteen minutes after which a medical cannabis recommendation would be issued. Respondent charged F.K. $120 for this service.

45. It was established that respondent committed errors and omissions in the care and treatment of F.K. in the following respects:

a. Respondent failed to substantiate F.K.'s reported substance abuse problem prior to issuing a diagnosis of alcoholism and failed to formulate a treatment plan. The medical records for F.K. lacked adequate documentation of physical examination, mental status examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent charged for recommendation renewal without conducting an examination of the patient.

Respondent's overall treatment of F.K. as above described represented an extreme departure from the standard of care.

Patient R.H.

46. Respondent saw R.H., a 50 year old male with a history of alcoholism and alcohol-related cerebellar ataxia on March 26, 1998. He issued a recommendation for marijuana for the treatment of "Alcoholic encephalopathy & Recovering alcoholic Insomnia & Posttraumatic arthritis." A follow-up questionnaire dated April 16, 2001 indicated "No Change" on these three diagnoses. Though the patient specified that he drinks up to ten cups of coffee daily, there was no comment in the record regarding its relevance to the insomnia complaint. The standard of practice for a psychiatrist diagnosing and evaluating insomnia is to obtain a full history including onset, type, exacerbating and ameliorating factors, medications taken, drugs, caffeine history, etc. The treatment plan should be directed at the primary cause of the insomnia, and may include both a pharmacologic and behavioral component. Respondent issued a physician's statement on May 3, 2001, indicating that R.H. was under his medical care and supervision for treatment of the serious medical conditions insomnia, traumatic arthritis and brain injury and that he recommended and approved his use of cannabis for these conditions. The medical record contains no documentation of traumatic arthritis.

47. It was established that respondent committed errors and omissions in the care and treatment of R.H. in the following respects:

a. Respondent failed to evaluate R.H.'s complaints of insomnia or to consider standard treatments for its underlying cause. He also failed to

evaluate and document R.H.'s arthritis. The medical records for R.H. lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent's statement that R.H. was under his medical care and supervision for post traumatic arthritis and chronic insomnia were false.

Respondent's overall treatment of R.H. as above described represented an extreme departure from the standard of care.

Patient W.H.

48. Respondent saw W.H., a 58 year old male with advanced multiple sclerosis, on November 1, 1998. W.H. was bedridden and under the care of a conservator who had requested respondent's services. Respondent met with the conservator and then saw W.H. for approximately 5 minutes. He obtained virtually no medical or psychiatric history from or about W.H. Medical records consist of an eligibility questionnaire partially completed by respondent, and several pages of medical records from other practitioners given to respondent by the conservator. He performed no physical and no mental status examination. He did not discuss the risks and benefits of cannabis with W.H. and documented no diagnosis or treatment plan. Respondent noted: "I looked at him and there he was lying in bed...He looked relatively comfortable...he appeared to be clean and appeared to be well-cared for, but again, I didn't lift the covers." Respondent issued a recommendation stating that W.H. was under his medical care and supervision for treatment of multiple sclerosis, and that he had discussed the medical risks and benefits of cannabis use with W.H.

Respondent avers that he briefly evaluated W.H. and observed ashtrays full of the ends of smoked joints near the bed. He opines that his condition was very serious, chronic and that he attained some relief from cannabis for muscle spasticity and depression. He avers that he got W.H. to articulate whether he knew about medical marijuana and was able to use it. Respondent believes discussion of the risks with W.H. was irrelevant because he had been using it for years. The conservator indicated to respondent that W.H. was deriving benefit from its use.

Dr. Duskin opines that though W.H. had severe difficulties with speech, and likely fatigued easily, this did not preclude a mental status examination, an evaluation of the painful muscle groups (rigidity, range of motion, etc.) and a focused evaluation of the pain intensity, duration, alleviating and exacerbating factors, efficacy of the current medication regimen, etc. If changing the dosing of existing medications (Baclofen and Ativan) had been tried in the past and was not efficacious, respondent did not document this fact and he was not in a position to recommend discontinuation or taper of either drug on a trial basis if either one or both were not helpful.

The standard of practice when a psychiatrist provides a focused consultation is to determine if follow-up is necessary, and if so to see the patient in follow-up at an appropriate

interval, depending upon the diagnosis and severity of the problem. Respondent failed to schedule a follow-up appointment at an appropriate interval. For pain management of a bedridden patient, planned follow-up in 6 – 12 months is inappropriate.

49. It was established that respondent committed errors and omissions in the care and treatment of W.H. in the following respects:

a. Respondent failed to adequately evaluate W.H.'s mental status.

b. Respondent failed to adequately evaluate W.H.'s complaints of pain and or muscle spasm. The medical records for W.H. lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan.

c. Respondent failed to evaluate the efficacy of W.H.'s current medication regimen.

d. Respondent failed to discuss the risks associated with marijuana and alternative treatments available to W.H.

e. Respondent failed to schedule a follow-up appointment for W.H. at an appropriate interval.

f. Respondent's statement that W.H. was under his medical care and supervision for treatment of Multiple Sclerosis, and that respondent had discussed the medical risks and benefits of cannabis use with W.H. was false.

Respondent's overall treatment of W.H. as above described represented an extreme departure from the standard of care.

Undercover Officer

50. In early 2003, Detective Steve Gossett, lead investigator for the Sonoma County Narcotics Task Force, was involved in a marijuana investigation of a couple implicated in illegal cultivation. He was provided the telephone number of an Oakland clinic where they had intended to obtain a medical marijuana recommendation. Detective Gossett made a telephone call to the clinic and made an appointment for himself using the undercover name Scott Burris. He went to the clinic, but because there were so many people waiting to be seen he paid $50 for a medical priority appointment for the following week. He returned to the clinic on February 7, 2003, signed in for an appointment, paid an additional $150 and was given a blank questionnaire to complete. He was asked by the receptionist to fill out all questions except for his current condition, and was told that "Ben" would be helping everyone with this particular section.

Detective Gossett disregarded instructions and filled in "sleep, stress, shoulder" for his current medical condition. A Ben Morgan came to assist him with the form and told him that stress was not the best medical condition. When Detective Gossett told him that his shoulder hurt, Ben asked him to move his shoulder up and down and then suggested that Detective Gossett state on the form that he had a dislocated shoulder.

Detective Gossett was escorted into a separate room where respondent was sitting behind a desk. Respondent reviewed the paperwork and asked him questions about his parents' health, his current medical problems and his stress over a pending criminal case. Detective Gossett made up a story about being arrested for possession of 54 grams of marijuana. He also told respondent that he did not have a regular doctor and that he was an unemployed construction worker. Respondent did not conduct any type of physical examination. He did not ask which shoulder had been injured.

Respondent observed that Detective Gossett's complexion was coarse and somewhat puffy, suggesting to him that he had a drinking problem, although he stopped short of diagnosing alcoholism. Respondent did advise him not to drink so much alcohol and suggested physical therapy. He issued a medical cannabis recommendation that indicated that Scott Burris (Detective Gossett) was under his medical care and supervision for treatment of serious medical conditions. The entire session lasted 10 to 15 minutes. Following the visit with respondent, Detective Gossett returned to the waiting area and was told to go to the Oakland Cannabis Club to obtain an identification card and that he and others were now "all legal" and could grow marijuana for sale to the different clubs. Ben Morgan advised the group to stick around for a "special treat" and Detective Gossett was given a bag of marijuana by an unknown female.

51. Respondent contends that Detective Gossett's law enforcement bias from past participation on a DEA task force, his prior statements that respondent was a "quack", his failure to wear a wire and his inconsistent statements all combine to make him a highly biased witness whose testimony should be discredited. Respondent notes that his overwhelming observation of Detective Gossett was that of a person with a serious drinking problem whose chronic shoulder pain had benefited from his alleged cannabis use and that respondent acted sincerely after performing a good faith medical examination. He acknowledges that he did not perform a physical examination. Respondent felt that marijuana would help ease his anxiety and his abuse of alcohol could be avoided. Respondent's challenge of Detective Gossett's credibility is somewhat moot because he does not dispute what occurred during the course of the medical interview itself. Their accounts differ only in terms of the length of the evaluation, respondent recalling that it was 20 minutes.

Respondent avers that he had no role in setting up the protocols and procedures followed at the Oakland Clinic. He was not the medical director and he had no authority to hire or supervise staff. He did not own or lease the property. He characterizes his position as that of an independent contractor there for the specific purpose of performing clinical evaluations. He was paid cash, $150 per patient seen. The medical records were his and they went home with him. Respondent had no role or knowledge of Ben Morgan's role in helping

patients prepare questionnaires and he was unaware that cannabis samples were being given away on the premises. Ben Morgan had asked respondent to participate in a number of different clinics. Respondent does not know if Ben Morgan had any health or medical license and he does not know if any other physicians worked out of the clinic. Respondent made no inquiries into whether the owners of the clinic were non-physicians and he is apparently unaware of laws governing physician practice under non-physicians. He avers that he did not view the clinic as carrying out full medical functions because it was a consultative venue as opposed to a medical clinic per se.

52. It was established that respondent committed errors or omissions in the care and treatment and interaction with an undercover officer in the following respects:

a. Respondent recommended treatment to the officer without conducting a physical examination. He undertook minimal effort to determine whether the officer was in fact suffering from any physical ailment or condition. The medical records for Detective Gossett lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent failed to provide follow-up or referral for the stated complaints.

c. Respondent's statement that the patient was under his medical care and supervision for treatment of a serious condition diagnosed after review of available records and in person medical examination was false.

Respondent's overall treatment of Detective Gossett as above described represented an extreme departure from the standard of care.

By virtue of his position as the physician practicing at the clinic, respondent assumed shared responsibility for the actions of the clinic facilitator/receptionist (Ben Morgan) in exaggerating information regarding patient medical conditions and for dispensation of marijuana on the premises. However, it was not established that respondent was aware of any of these practices. Whether respondent's license should be subject to disciplinary action for the acts of Ben Morgan is reserved for discussion in the Legal Conclusions section.

Cost Recovery

53. The Board has incurred the following costs in connection with the investigation and prosecution of this case:

Medical Board of California Investigative Services

Year	Hours[7]	Hourly Rate	Charges
1999	4	103.07	$ 412.28
2000	234	109.93	25,723.62
2001	52	110.84	5,763.68
2002	78	110.84	8,645.52

An additional 61 hours @ $100 were spent by medical experts for reviewing and evaluating case-related materials, report writing, hearing preparation and examinations. Board investigative costs total $46,645.16.

Attorney General Costs

The costs of prosecution by the Department of Justice for Deputy Attorneys General Jane Zack Simon and Lawrence A. Mercer total $23,608, and $30,884, respectively. The declarations of both have been reviewed and the time and charges are found to be in reasonable performance of tasks necessary for the prosecution of this case.[8] Investigative and prosecution costs total $101,137.

LEGAL CONCLUSIONS

Immunity

1. Respondent contends that the Compassionate Use Act of 1996 confers absolute immunity upon a licensed physician who recommends medical marijuana. He relies upon Health and Safety Code section 11362.5, subdivision (c), which provides:

[7] Approximately 27 hours were spent conducting interviews, 53 hours for record review, 53 hours for travel, 173 hours on report writing and 62 hours on telephone, subpoena service, court, meetings with the Attorney General and Medical Consultant

[8] Though a breakout of hours for each task was not provided, cost certifications detailed tasks including 1) conducting an initial case evaluation, 2) obtaining, reading and reviewing the investigative material and requesting further investigation, as needed; 3) drafting pleadings, subpoenas, correspondence, memoranda, and other case-related documents; 4) researching relevant points of law and fact; 5) locating and interviewing witnesses and potential witnesses; 6) consulting and/or meeting with colleague deputies, supervisory staff, experts, client staff, and investigators; 7) communicating and corresponding with respondent's counsel; 8) providing and requesting discovery; 9) preparing for and attending trial setting, status, prehearing and settlement conferences, as required, and 10) preparing for hearing.

> Notwithstanding any other provision of law, no physician in this state shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes.

Respondent believes that his medical marijuana recommendations should be protected by the "absolute immunity" afforded under section 11362.5. He asserts that California law enforcement officials from various jurisdictions began bringing complaints against him to the Board based almost entirely on their own failed prosecutions of various medical marijuana patients and that no patient has initiated or joined a complaint against respondent. He suggests that this action is politically motivated by law enforcement officials who are now working in tandem with the Board to circumvent Proposition 215, along with other protections afforded him and his patients under the First Amendment and patient confidentiality laws.

Complainant characterizes this case as having "virtually nothing to do with medical marijuana" and notes that Board medical expert Dr. Duskin was not even critical of the recommendation, or use, of marijuana medicinally. Rather, complainant's criticism is leveled at respondent's alleged failure in virtually every case to examine the patient, to obtain a history, to perform an appropriate work up of the patient's symptoms and findings, or to follow up with or monitor the patients.

2. Respondent contends that by its use of the term "notwithstanding any other provision of law," a legal term of art, the Compassionate Use Act confers absolute immunity of doctors for their actions related to recommending or approving medical marijuana. He notes that conduct necessary to perform the immunized act falls within the scope of the grant of immunity and is thus not subject to Board discipline. Specifically, he argues that a doctor must always take some action attendant upon approving or recommending medical marijuana and that recognizing immunity for the approval or recommendation, but not the *approving* or *recommending*, is logically impossible, and legally unsupportable. Complainant would instead draw a clear distinction between the physician's recommendation, and the process by which that recommendation was reached.

Generally, decisions about when, where or how to carry out the immunized act is conduct that comes within the privilege because the methods of doing the immunized act are typically matters so intimately linked to the immunized act itself "that they are within the scope of the privilege." (*Katsaris* v. *Cook* (1986) 180 Cal.App.3d 256, 266-267; *Scozzafava* v. *Lieb* (1987) 190 Cal.App.3d 1575.) Both *Katsaris* and *Scozzafava* considered a statute that immunized the killing of dogs trespassing on the property of livestock owners. In *Scozzafava*, a chicken farmer's employee wounded a dog that was attacking the farmer's chickens. The dog returned to its owner, who then brought the dog to a veterinarian. The dog later bit a veterinary assistant as she was attempting to pick it up. The veterinary assistant brought a negligence action against the chicken farmer, who raised the immunity statute as a defense. In construing the immunity rather broadly to bar the claim the Court of Appeal held:

> The context of *Katsaris* makes it clear that the test of acts or conduct "necessary to the killing" is not rigidly limited to such obvious incidents as loading and aiming, but is instead generously construed so as to reach categories of specific decisions pertaining to more general areas such as employment practices, business policies, and most manner of matters concerning firearms. These are precisely the issues for which plaintiff seeks to impose liability on defendant. Just as we did in *Katsaris*, we hold that these acts and omissions constitute decisions necessary to the exercise of the privilege to kill.

(*Scozzafava* v. *Lieb*, *supra*, 190 Cal.App.3d at 1581.)

Respondent contends that every single fact relied upon by the Board refers to the methods by which he went about recommending or approving the use of marijuana, and nothing more. He believes that the Board has no jurisdiction or authority to discipline, or even investigate him for the methods by which he recommended medical marijuana because such matters are shielded by absolute immunity.

3. Immunity statutes, like privileges, are either absolute or conditional. Absolutely privileged conduct does not permit any remedy by way of a civil action, regardless of whether or not the privileged conduct was undertaken in bad faith or with malice. (*Saroyan v. Burkett* (1962) 57 Cal.2d 706, 708) A qualified or conditional privilege protects the actor only if he or she acts for the purpose of advancing or protecting the interest which the privilege seeks to protect. "Thus, under a qualified privilege an actor may be liable for conduct which he undertakes with an improper motive. Likewise a qualified privilege may be lost if the actor engages in conduct outside the scope of the privilege, thus 'abusing' it." (*Katsaris* v. *Cook*, *supra*, 180 Cal.App.3d at 265.) To determine the scope of privilege the analytical model adopted by courts in defamation cases has been applied to immunity statutes, incorporating a two step analysis. (*Id.* at p. 266.) First, what is the policy rationale which underlies the privilege? Second, does that policy justify applying the privilege to this particular conduct? (*Ibid.*; *Bradley* v. *Hartford Acc. & Indem. Co.* (1973) 30 Cal.App.3d 818, 824.)

In this case the immunity afforded physicians under Health and Safety Code section 11362.5 does appear to be conditional. The language of the Compassionate Use Act is instructive in this regard. Subdivision (b)(2) provides that "Nothing in this section shall be construed to supersede legislation prohibiting persons from engaging in conduct that endangers others, nor to condone the diversion of marijuana for nonmedical purposes." One of the Act's purposes is to ensure that seriously ill Californians have the right to obtain and use marijuana for "medical purposes" and "where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana." Yet, the Act also expressly affirms public policy against conduct that endangers others or the diversion of marijuana for nonmedical purposes. It is left for the physician, as gatekeeper, to ensure that marijuana is used for "medical purposes" to benefit the seriously ill. Under these circumstances it is presumed that

physicians who recommend marijuana under the Act will follow accepted medical practice standards and make good faith recommendations based on honest medical judgments. (*Conant* v. *McCaffrey* (2000 WL 1281174) Complainant correctly notes that to hold otherwise and to extend absolute immunity to physicians would allow them to simply issue marijuana recommendations without the exercise of sound medical judgment and with no oversight.

4. The primary function of the Board is protection of the public. (Bus. & Prof. Code, § 2229, subd. (a).) The various provisions of the Medical Practice Act dealing with physician misconduct are designed to promote public safety by ensuring that the standards of practice for physicians are maintained and enforced. The language of the Compassionate Use Act does not conflict with these goals. Thus, the immunity afforded physicians who recommend marijuana to patients for medical purposes provides that they may not be punished, or denied any right or privilege, for having made that recommendation. However, it does not exempt them from standards or regulations generally applicable to physicians, including those that govern the manner or process by which the physician's recommendation was reached.[9] Judge Kozinski reached the same conclusion in contemplating the role of the physician in determining legal and illegal marijuana use under the Compassionate Use Act:

> [D]octors are performing their normal function as doctors and, in so doing, are determining who is exempt from punishment under state law. If a doctor abuses this privilege by recommending marijuana without examining the patient, without conducting tests, without considering the patient's medical history or without otherwise following standard medical procedures, he will run afoul of state as well as federal law. But doctors who recommend medical marijuana to patients after complying with accepted medical procedures are not acting as drug dealers; they are acting in their professional role in conformity with the standards of the state where they are licensed to practice medicine.

(*Conant* v. *Walters* (2002) 309 F.3d 629, 647.)

Application of Business and Professions Code Section 2242

5. Respondent contends that he did not "prescribe" marijuana and for that reason he cannot be held accountable for his failure to conduct a prior good faith examination nor for his failure to determine that a medical indication existed for treatment recommended by him. Business and Professions Code section 2242 provides that it is unprofessional conduct for a physician to prescribe, dispense or furnish drugs without a good faith prior examination and medical indication therefore. Respondent did not "prescribe" marijuana because one cannot prescribe a Schedule I controlled substance. (Health & Saf. Code, § 11054, subd. (d)(13).)

[9] That respondent also has a First Amendment right to recommend medical marijuana to his patients is undisputed. (*Conant* v. *Walters* (2002) 309 F.3d 629.) The Board has not imposed any content-based restrictions on his speech and he is able to communicate freely, candidly and meaningfully with his patients and to offer sincere medical judgments about the pros and cons of medical marijuana. For these reasons respondent's First Amendment challenge to the Board's action is overruled.

The administrative law judge found that the standard for prescribing cannot be distinguished from the standard of practice which proscribes recommending any other treatment without examination or medical work-up and the standard of practice is no different for "recommending" or "approving" marijuana than it is for prescribing any other medication.

However, in its Judgment and Order in this matter dated November 2, 2006, the Superior Court found, as a matter of law, that "a recommendation for marijuana is not a 'prescription' and as such, respondent was not subject to discipline pursuant to Business and Professions code section 2242". The board, therefore has excluded Business and Professions code section 2242 from consideration on remand.

Standard of Practice

6. The standard of practice for conducting a medical cannabis evaluation is as set forth in Finding 16. It is identical to that followed by physicians in recommending any other treatment or medication and it applies regardless of whether the physician is acting as a treating or as a consulting physician. Although focused on the patient's complaints, the evaluation does not disregard accepted standards of medical responsibility. These standards include history and physical examination of the patient; development of a treatment plan with objectives; provision of informed consent; and periodic review of the treatment's efficacy. When a cannabis recommendation is being made for a psychiatric condition the examination would additionally entail a mental status examination. In such cases a physical examination might not be included, or might only include a limited physical examination appropriate to the clinical situation. In sum, the standard of practice for a physician recommending marijuana to a patient is the same as that for recommending any other treatment or medication.

The standard of practice requires that the evaluation be supported by adequate documentation. That documentation must reflect the physician's initial history and physical/mental status exam, evaluation of each condition in question and a diagnosis and/or differential diagnosis. A physician must document pertinent physical and/or psychiatric findings, referrals, a treatment plan and follow-up. Business and Professions Code section 2266 provides that "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

Disciplinary Grounds

7. Under Business and Professions Code section 2234 the Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes gross negligence, repeated acts of negligence, incompetence and the commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions or duties of a physician and surgeon. (Bus. & Prof. Code, § 2234, subds. (b) – (e).)

8. Cause for disciplinary action exists under Business and Professions Code section 2234, subdivision (b), by reason of the matters set forth in Findings 17, 21, 23, 25, 27, 28, 30, 32, 35, 37, 39, 41, 43, 45, 47, 49 and 52. Respondent's errors and omissions in connection with his care and treatment of sixteen patients and the undercover officer constituted gross negligence.

9. Cause for disciplinary action exists under Business and Professions Code section 2234, subdivision (c), by reason of the matters set forth in Findings 17, 21, 23, 25, 27, 28, 30, 32, 35, 37, 39, 41, 43, 45, 47, 49 and 52. Respondent's errors and omissions in connection with his care and treatment of sixteen patients and the undercover officer constituted repeated negligent acts.

10. No cause for disciplinary action exists under Business and Professions Code section 2234, subdivision (d), by reason of the matters set forth in Finding 54. The above described errors and omissions do not reflect respondent's incompetence, but rather choices consistent with his belief that a different standard was applicable to the evaluation of patients for purposes of medical cannabis recommendations. Incompetence generally is defined as a lack of knowledge or ability in the discharging of professional obligations and it often results from a correctable fault or defect. (*James* v. *Board of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1109.) There are no apparent deficits in his education, knowledge, training, or skills as a physician. He is clearly capable of observing standard medical evaluation protocols for history, physical and mental status examination, development of a treatment plan, informed consent and follow up or referral. He has also demonstrated that he can maintain proper records when he chooses to do so.

11. No cause for disciplinary action exists under Business and Professions Code section 2234, subdivision (e), by reason of the matters set forth in Finding 52. It was not established that respondent had any awareness of the activities of Ben Morgan, an element necessary to a finding that he committed an act involving "dishonesty or corruption" under this particular subdivision. Generally, a licensee is responsible for the acts of agents, whether independent contractors or employees, acting in the course of the licensee's business. This is true even when the licensee does not have actual knowledge of the agent's activities. Thus, a licensee was charged with submitting false statements in MediCal billings that were done through an office manager without his review, and a pharmacist may be disciplined by the pharmacy board for the unlawful acts of his employee for illegally filling prescriptions. (*Heisenberg* v. *Myers* (1983) 148 Cal.App.3d 814, 824; *Arenstein* v. *State Board of Pharmacy* (1968) 265 Cal.App.2d 179, 192.) But even where respondent is ultimately responsible for the actions of agents, it does not also follow that he engaged in unprofessional conduct. Unprofessional conduct under section 2234, subdivision (e) contemplates more than vicarious liability for the actions of an agent and a licensee should not be found to have engaged in unprofessional conduct unless directly implicated for committing acts involving "dishonesty or corruption." A violation of this subdivision (e) should be based upon findings of respondent's own acts of dishonesty or corruption, or on

such acts by those working for him of which he had personal knowledge and which he actually ratified.[10] That is not the case here.

12. The Superior Court has found that cause for disciplinary action does not exist under Business and Professions Code section 2242.

13. Cause for disciplinary action exists under Business and Professions Code section 2266, by reason of the matters set forth in Findings 17, 21, 23, 25, 27, 28, 30, 32, 35, 37, 39, 41, 43, 45, 47, 49 and 52. Respondent failed to maintain adequate and accurate records relating to the provision of services to his patients.

14. Cost Recovery. Under Business and Professions Code section 125.3 the Board may request the administrative law judge to direct any licentiate found to have committed a violation or violations of the licensing act to pay the Board a sum not to exceed the reasonable costs of the investigation and enforcement of the case. Requested costs total $101,137. (See Finding 53.)

The Board must not assess the full costs of investigation and prosecution when to do so will unfairly penalize a licensee who has committed some misconduct, but who has used the hearing process to obtain dismissal of other charges or a reduction in the severity of the discipline imposed. The Board must consider the licensee's "subjective good faith belief in the merits of his or her position" and whether the licensee has raised a "colorable challenge" to the proposed discipline. (*Zuckerman* v. *Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, 45.) Such factors have been considered in this matter.

This is a case of first impression. The scope of physician immunity under Health and Safety Code section 11362.5 and other legal issues had not been considered previously and required greater time and preparation on the part of complainant. Respondent should not bear the full burden of such costs. The Board acknowledged in its own policy statement on Proposition 215 that there was "a great deal of confusion concerning the role of physicians under this law" and following passage of the Compassionate Use Act there was uncertainty over what protocols physicians should follow in making medical cannabis recommendations. Some uncertainty persisted, notwithstanding the Board's January 1997 policy statement. There was credible testimony that among the handful of physicians who consult regularly on medical cannabis issues there was no uniform agreement on practice standards. Respondent had a good faith belief in the merits of his position and he raised a colorable challenge, factually and legally, to accusation allegations. He successfully defended allegations against him based upon incompetence, dishonesty or corruption. An adjustment of approximately 25 percent would fairly and equitably accounts for these several factors. Accordingly, reasonable investigation and prosecution costs are adjusted to $75,000.

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[10] See also *James* v. *Board of Dental Examiners*, *supra*, 172 Cal.App.3d at 1110, where the Court of Appeal noted: "An important factor in our review is that any attack to revoke the personal license to practice dentistry of Dr. James of course must be based upon findings of his own acts of misfeasance, or on such acts by those working with him of which he had personal knowledge and which he actually ratified."

However, effective January 1, 2006, Business and Professions code section 125.3 was changed to prohibit the board from requesting or obtaining from a physician and surgeon the costs of investigation and prosecution of a disciplinary proceeding. Therefore, the board waives cost recovery in this matter.

15. Other Considerations. The protection of the public is the Board's highest priority. Yet, in determining appropriate disciplinary action and in exercising disciplinary authority the Board shall, whenever possible, "take action that is calculated to aid in the rehabilitation of the licensee." (Bus. & Prof. Code, § 2229.) This includes ordering restrictions as are indicated by the evidence. Respondent's competence was really not at issue in this case. He understands what the traditional medical examination model entails. He has applied it when patients have been evaluated for reasons outside his focused medical cannabis consultation model and indeed, when Dr. Duskin was asked to review nine of respondent's inpatient case files, she found all to be within the standard of care. In a few cases she determined his care to be excellent. He is clearly capable of observing standard medical evaluation protocols for history, physical and mental status examination, development of a treatment plan, informed consent and follow up or referral. He has also demonstrated that he can maintain proper records in such cases. Dishonesty or corruption allegations against respondent were not sustained.

Respondent strongly believed that Proposition 215 contemplated something very different than the traditional medical examination model. Such beliefs were based upon his active involvement in efforts to legalize marijuana for medical purposes and his own good faith interpretation of Proposition 215. This, combined with his practice experience as a medical cannabis consultant, resulted in rather rigid yet consistent adherence to the more focused medical cannabis consultation model. He did so even after he was on notice of the accusation allegations. The question now is whether he is willing and able to set aside these very strong views regarding the type of examination he feels is necessary to support a medical cannabis recommendation and comply with traditional medical examination standards. Complainant characterizes respondent as "obviously intransigent" and is concerned that this will impede not only his ability to successfully complete probation, but the Board's ability to adequately supervise and monitor his activities. Respondent should only be placed on probation if there is a reasonable likelihood that he will conform his practice to acceptable standards, and if he can reasonably be expected to abide by necessary practice restrictions and oversight. Respondent has certainly been a forceful advocate for his approach throughout the investigation, prosecution and hearing of this case. He has raised colorable factual and legal defenses to accusation allegations and several first impression issues were considered in this case. Importantly, he has indicated that he would be willing to conform his practices if required and it is not unreasonable to expect that he will do so.[11] He should be given that opportunity.

[11] Respondent's failure to conform his behaviors after he was on notice that the Board took issue with his evaluation process and his lack of medical documentation is troubling, but it is countered somewhat by his sincere belief that he was breaking new ground in setting standards under Proposition 215 for recommending and approving medical cannabis. He has also persisted in his belief that this case has been driven from the start by federal and state government officials opposed to Proposition 215.

It would therefore not be contrary to the public interest to place respondent on probation at this time. One of the conditions should include appointment of a practice monitor and the development of a monitoring plan. Respondent has suggested that if his practice were monitored or supervised by a physician who was not a medical cannabis consultant he would "reject" it.[12] This is a case where compliance can best be ensured through a physician monitor/supervisor approved by the Board. This physician monitor may be a medical cannabis consultant, but this is certainly not a necessary requirement. The Board normally allows licensees, in lieu of having a practice monitor, to participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education (PACE) Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. While respondent may opt to participate in program such as PACE, it remains critical that an approved practice monitor be in place to monitor his practice. Participation in PACE should not be done in lieu of having a practice monitor.

16. Reconsideration After Remand. Consistent with the Superior Court's Judgment and Order, the board has reconsidered its decision in this matter. It finds that the original Order is appropriate for the violations that remain.

Respondent has been found, by clear and convincing evidence, to have been grossly negligent and also to have committed repeated negligent acts in his care and treatment of 16 patients and 1 undercover officer. Those two types of violations, standing alone, would warrant the Order initially adopted. That Order is consistent with the board's Disciplinary Guidelines, which call for a minimum of stayed revocation and 5 years probation on terms and conditions. The board finds no reason to deviate from the Order initially imposed, given the nature and extent of respondent's misconduct and the sheer number of patients. However, for the reasons indicated in Legal Conclusion No. 14, the board has stricken cost recovery from the order.

ORDER

Physician's and Surgeon's Certificate No. G-9124 issued to respondent Tod H. Mikuriya, M.D. is revoked pursuant to Legal Conclusions 8, 9, 12 and 13, separately and for

[12] Respondent's own expert, also a medical cannabis consultant, documents all medical cannabis evaluations and conducts a good faith examination that is identical to any other medical evaluation he performs. He does so consistent with his philosophy of practicing excellent medicine in all cases. If a medical cannabis consultant such as Dr. Denney performs the same medical evaluation for all patients, then it should really make no difference whether a physician assigned to monitor respondent's practice is also a medical cannabis consultant.

all of them. However, revocation is stayed and respondent is placed on probation for five (5) years upon the following terms and conditions:

1. Monitoring of Practice. Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Division or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Division, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Division or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

The monitor shall submit a quarterly written report to the Division or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine or billing, or both, and whether respondent is practicing medicine safely, billing appropriately or both.

It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Division or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Division or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 days of

the resignation or unavailability of the monitor, respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the Division or designee.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

2. Notification. Prior to engaging in the practice of medicine respondent shall provide a true copy of the Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days. This condition shall apply to any change in hospitals, other facilities or insurance carrier.

3. Supervision of Physician Assistants. During probation, respondent is prohibited from supervising physician assistants.

4. Obey All Laws. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

5. Quarterly Declarations. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

6. Probation Unit Compliance. Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b). Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Division or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

7. Interview with the Division or Its Designee. Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Division or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

8. Residing or Practicing Out-of-State. In the event respondent should leave the State of California to reside or to practice respondent shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California totals two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

9. Failure to Practice Medicine - California Resident. In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any

activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

10. Violation of Probation. Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

11. License Surrender. Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Division or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action.

If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

12. Probation Monitoring Costs. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

13. Completion of Probation. Respondent shall comply with all financial obligations (e.g., cost recovery, restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon completion successful of probation, respondent's certificate shall be fully restored.

This decision shall become effective at 5:00 pm on March 12, 2007

IT IS SO ORDERED this 9th day of February, 2007.

BARBARA YAROSLAVSKY
Chairperson , Panel B
Division of Medical Quality
Medical Board of California

EXHIBIT A

ORIGINAL

COPY

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Attorneys for Respondent Medical Board of California

FILED
ENDORSED
NOV - 2 2006
By FRANK TEMMERMAN
Deputy Clerk

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF SACRAMENTO

TOD H. MIKURIYA, M.D.,

Petitioner,

v.

MEDICAL BOARD OF CALIFORNIA

Respondent.

Case No. 04CS00477

JUDGMENT AND ORDER RE: PETITION FOR WRIT OF ADMINISTRATIVE MANDATE

KEYD
37

The hearing on the Petition for Writ of Administrative Mandate (the "Petition") in the above-entitled matter was heard in Department 20 on February 10, 2006, before the Honorable Jack Sapunor, Judge Presiding. Petitioner Tod Mikuriya, M.D., appeared in court, and was represented by Scott Candell, Attorney at Law; Medical Board of California, appeared by its counsel, Bill Lockyer, Attorney General of the State of California, by Lawrence A. Mercer and Jane Zack Simon, Deputy Attorneys General. The record of the administrative proceeding was received in evidence and reviewed by the Court. The Court read all the pleadings on file in the action, and the matter was orally argued and submitted.

Exercising its independent judgment, the Court therefore ORDERS, ADJUDGES AND DECREES that:

1. The Court finds that as a matter of law, a recommendation for marijuana is not a "prescription" and as such, respondent was not subject to discipline pursuant to Business and Professions Code section 2242. The petition for writ of mandate is granted solely to the extent that the Board based its Decision on a finding of unprofessional conduct based on a violation of section 2242. Accordingly, a peremptory writ of mandamus shall issue from this Court, remanding this matter to respondent for reconsideration of its Decision in light of this finding.

2. On all other grounds, the Petition is DENIED.

DATED: November 2, 2006

JACK SAPUNOR
Judge of the Superior Court

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
PHYSICIAN'S DIVERSION PROGRAM
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Agenda Item 12-B

DIVERSION EVALUATION COMMITTEE MEMBERS FOR RE-APPOINTMENT
July 2007

Shannon V. Chavez

Dr. Chavez is a physician member whose first term expires in July 2007. Dr. Chavez has an excellent attendance record and program staff believes that she is a solid Diversion Evaluation Committee Member. I support her re-appointment.

REFER TO ITEMS 5 AND 6

IN THE DIVERSION COMMITTEE

AGENDA PACKET FOR

PROPOSALS TO AMEND/ADD

REGULATIONS